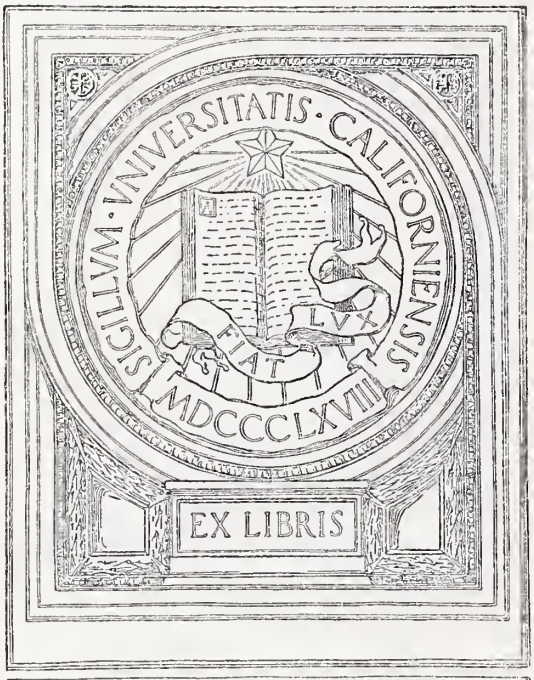
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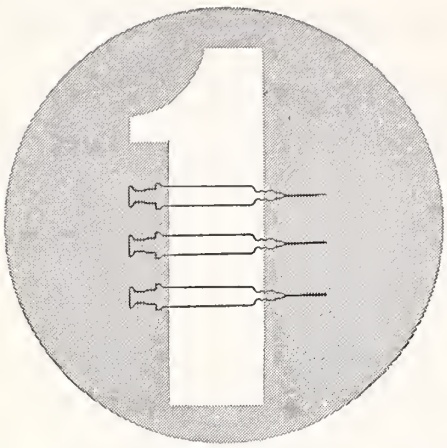
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The
CONNECTICUT STATE MEDICAL JOURNAL

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THE CONSERVATIVE TREATMENT OF THROMBO-EMBOLIC DISEASES

IRVING S. WRIGHT, M.D., *New York City*

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THIS discussion will not be confined to the peripheral vessels, because it is impossible to divorce the heart from the rest of the circulation. Thrombo-embolic phenomena are of the greatest importance. They are important because they produce the terminal fatal episode in the lives of more patients over fifty than any other pathological mechanism. A very large percentage of these patients suffering from thrombi or emboli in the vessels of the brain, the kidney, the heart, the legs, or elsewhere, do not or would not die from the effects of the original thrombus. Death results far more often from subsequent developments, including (a) a propagation of the thrombus to block off additional arteries or veins which are strategically located so that they interfere with the vital function of the organ supplied; (b) the breaking off of emboli from the original thrombus, which, when transported by blood currents, lodge at critical points, interfering with the blood flow and producing death of the local tissues, or in the case of emboli of sufficient size, lodging in the heart, or the pulmonary, or the cerebral circuit, producing sudden death; (c) the development of secondary thrombi which may in turn give off emboli. Examples of this type of process are represented by mural thrombi seen with coronary thrombosis, thrombi in the veins of the legs upon prolonged bed rest, as with coronary thrombosis, and multiple thrombo-phlebitis. Experience has demonstrated that if a patient survives the first attack of thrombosis, or indeed a subsequent attack, he may live for many months, or even years. It is therefore encumbent upon us to do everything in our power to bring about the survival of each individual through each individual attack. Interruption of the thrombo-embolic process presents a logical approach to the problem. Our former methods of treatment of these thrombo-embolic phenomena have never been aimed at modifying the fundamental process involved. Indeed, frequently, as in the case of coronary thrombosis, the combination of complete rest, restriction of fluids, narcosis and mercurial diuretics, have all encouraged further thrombosis, either in the vessels or the chambers of the heart, or in the veins elsewhere. The question of the effect of xanthines and digitalis will be discussed later. It is seen, therefore, that most serious study must be given to this problem and we have been fortunate in having heparin and dicumarol available, the use of either of which can apparently interrupt the thrombo-embolic process under favorable conditions. It is our purpose, therefore, to review the present status of the use of these substances in the treatment of cardio-vascular diseases. Some of the common complications which we fear as part of the thrombo-embolic process include large thrombi which may have been embolic originally landing, for example, at the junction of the femoral artery. Other emboli may lodge in the pulmonary arteries. We have seen one which involved both pulmonary arteries, having folded itself across extending from one to the other. This came from the veins of a leg, and incidentally from a patient who had no symptoms whatsoever regarding discomfort, or pain, or

Discussion presented before the Connecticut State Medical Society, April 24, 1947

anything that made the physicians suspect a thrombosis or a thrombo-phlebitis in the leg. This patient also had an additional embolus which lodged in a chamber of the heart. These are common and the most feared complications.

The mast cells according to Jorpes and others have been demonstrated to be concentrated storehouses of heparin in animals, and they apparently supply heparin into the blood stream directly. Whether one has a thrombosis or not depends in part on the balance of the amount of heparin which is available in the blood stream as against coagulating substances, such as thromboplastin and others. The other anticoagulant under discussion this afternoon is now known as dicumarol. It occurs in nature and was first isolated from spoiled sweet clover in which the cumarin of the normal clover has changed to dicumarin, which becomes an anticoagulant substance. Heparin can be administered by several methods, as Dr. Duryee has mentioned. It can be given by continuous intravenous infusion or it can be given by intermittent injections, and lastly it can be given by means of the Pitkin menstruum. Using it by means of a continuous intravenous infusion one encounters the difficulty that it has to be watched very carefully. The clotting time should be determined at first once an hour and later we do it once in two hours. To allow the patient to have a continuous drip for a period of several or more hours without observation is dangerous and has produced death. On the other hand, one can maintain a fairly uniform level, and the objective should be to keep the clotting time between 20 and 40 or 45 minutes, longer is not necessary. The Swedish workers, Bauer, Jorpes, Zilliacus, and others have used the intermittent injection method. They inject 100 to 125 mg. (Swedish Standard) of heparin every 3 hours, not bothering to do clotting time tests. This has been done in many country hospitals throughout Sweden with relatively few accidents. The dosage which they have mentioned in their papers cannot be utilized safely in this country because the heparin of Sweden is standardized according to the Swedish standard, which is definitely a weaker standard than the "temporary International Standard" which is used in this country. With American made heparin 75 mg. or 50 mg. is usually enough. We do a clotting time before starting, using the Lee-White technique, a clotting time one half hour after the injection and one two-and-a-half hours or perhaps a little closer to the time when we give the next injection of heparin. We like to have response so that while it may rise high shortly after the injection, the clotting time will fall to approximately 15 or 20 minutes at the end of the period of two and one half to three hours. Curiously, relatively few accidents have followed this method, although we were very much afraid of it because of the high levels of clotting time which occur rather rapidly after the injection. All of this mitigates against the free use and prolonged use of heparin. The use of the heparin in a slowly releasing menstruum has been delayed by the fact that it is difficult to control, it is painful, it produces nausea in some cases and abscesses have occurred at the site of injection. Theoretically a slowly acting medium would be an ideal thing and it may be worked out yet. Dicumarol is slow to act and its effects are cumulative. The effects can be counteracted by vitamin K and by transfusions of whole fresh blood. Details of this can be obtained from papers by Barker, Allen, Wright and others. The effects on thrombosis can be well illustrated by cases collected in two parts of the world during the war period when communication was poor, and by different workers. The European workers had roughly 1,500 cases and the Mayo Clinic workers had approximately 1,650 cases. Of these, 48 per cent of the former and 53 per cent of the latter, or roughly 50 per cent of each, suffered a pulmonary embolism, and roughly 20 per cent in each series had a fatal, pulmonary embolism. I think it is very important that these two groups, working at such widespread geographical distances, came out with almost identical figures. These were surgical patients who had developed thrombosis. Obstetrical patients apparently have a somewhat different prognosis, even if they are not treated by the use of anticoagulants. There were 749 in one obstetrical series and 420 in another. Pulmonary emboli varied considerably from 16 to 36 per cent but the fatal emboli were very close, running approximately 4 per cent. It is interesting that once thrombosis was present the obstetrical groups developed about 4 per cent fatal emboli while the surgical groups developed 20 per cent. The explanation for that has not been made clear as yet. One possibility which has occurred to us is the fact that a fair amount of the thrombo-phlebitis in obstetrics may occur in pelvic veins, the lumina of which are not large enough to produce fatal emboli, whereas in the surgical cases they frequently come from the larger leg veins. We know that obstetrical cases do have

ot too infrequently, thromboses of the larger eins too, but apparently many of the emboli arise rom the smaller pelvic veins. In a group of some 400 ases which we have treated or supervised of which here were 277 cases of non embolic thrombo-phlebitis, and which were treated with anticoagulant herapy there were three emboli which were recognized after treatment had begun. In patients who ad already had emboli, of which there were 123, wo emboli occurred despite adequate anticoagulant herapy. One embolus occurred after cessation of reatment. No deaths occurred from emboli in this eries. There were some complications and some eaths, however, from other causes. We were unable o control the thrombophlebitis in five of these ases, two because of the presence of malignancy of he liver, one with malignancy of the pancreas, and ne from malignancy of the colon. There was one ase of phlebitis migrans which failed to respond nd ultimately was fatal, after this chart was made p, so that we really have had five fatal cases from uch causes. There were also hemorrhagic manifestations, twenty-one of which occurred with manifestations of purpura of the skin and mucous membranes. In the last 200 cases, however, purpuric manifestations have been very rare, largely because ve have learned how to use these drugs. In the ast 200 cases there have been two cases of frank ematuria. I am not referring to an increase in ed blood cells, microscopic in order, and representing a problem of very little seriousness in the se of these drugs. There were no deaths from nticoagulant therapy in this series. In considering series of Barker's cases with non fatal pulmonary embolism and infarction prior to treatment here were 678 in the control group, 180 in the icumarol-treated group. In the control group pproximately 45 per cent, or 297, had subsequent enous thrombosis, pulmonary embolism, or infarcton, whereas in the dicumarol-treated group, two, r 1.1 per cent, had subsequent venous thrombosis, ulmonary embolism, or infarction. Subsequent atal pulmonary embolism occurred in nearly 20 er cent in the control group, and less than 1 per ent in the treated group. In other words, if a perpn has one embolism and is treated by conservative neasures, and this does not include the treatment y means of surgery, the patient has nearly a 50 per ent chance of having further complications and a o per cent chance of dying, as contrasted by those reated with anticoagulants where the percentage in each case approximates 1 per cent. To demonstrate that this is not a local result, the results from twelve hospitals in Sweden have been compiled by Zilliacus. Under the conservative treatment of 543 cases there were 88 deaths or 16 per cent. In the heparin and dicumarol-treated group there were roughly 900 cases, or nearly twice this number, and the number of deaths was four, and the percentage was 0.45 per cent, about one half or 1 per cent, where if these figures were comparable there should have been about 150 deaths. Zilliacus' further studies involved the individuals who had a sudden pulmonary embolism without other signs of thrombolic symptoms. The first attack killed 114 patients, so that they had no chance for treatment. When the first attack was non fatal, of those who received conservative therapy, 65, 21 died, roughly 30 per cent. Of those who received either heparin or heparin and dicumarol, there were 103, nearly twice that many, with no deaths. These figures in reference to peripheral thrombi are sufficiently impressive so that they require no further elaboration.

In treating either peripheral or cardiac thrombi we use the following technique: 1. Determine the prothrombin activity and the clotting time, using the Quick or the Link-Shapiro method for the prothrombin activity and the Lee-White method for the clotting time. We are now working with lusteroid tubes and with paraffin-lined tubes in an endeavor to improve on the clotting-time tests which are not very satisfactory, but thus far have not been very happy with our results. 2. If the patient is an active embolic case we use heparin for the first 36-48 hours by one of the methods we have discussed. 3. If the prothrombin is normal or lower, we give 300 mg. of dicumarol the first day. 4. The prothrombin activity is then determined every day. Before any dose of dicumarol is ever given the clinician must know the prothrombin level for that day in order to determine the correct dosage. 5. The dosage is as follows: give 200-300 mg. daily until the patient has a prothrombin time of 30 seconds; 100 or 200 mg. until it reaches 35 seconds; and none after it has reached a level of 35 seconds. We then follow the curve daily and it usually continues to rise; it often reaches 50 or 60 seconds and then starts to turn and exhibit a downward trend. When it reaches 30 seconds again we then begin to give 100 or 200 mg. daily, depending on the sensitivity of the patient. 6. If the curve continues to rise and it goes above 70 seconds, we now give 72 mg. of vitamin

K intravenously and repeat it once. That is usually sufficient to bring the curve down without any difficulty. 7. If hemorrhagic manifestations of serious degree develop give vitamin K up to four doses, or whole fresh blood transfusions. 8. The duration of treatment is usually for from 14 to 28 days after the last episode of Thrombo-embolic activity.

Leaving the veins for the moment we will discuss thrombo-embolic problems arising in the heart which often result in emboli to the peripheral circulation and pulmonary emboli. The first group of heart cases which we treated with anticoagulants were those with coronary thrombosis and myocardial infarction. Complicated cases were used in order to learn as much as we could about the value or lack of value of anticoagulant therapy. These individuals had either had multiple thrombi, propagation of the original coronary thrombus, or repeated emboli from mural thrombi or from the veins of the legs, or combinations of these. Of the first group of complicated cases there were 46. In 41 of these cases there were no further thrombo-embolic episodes after the beginning of anticoagulant therapy. Six of them later died of cardiac failure due to the infarction. To this first group we added 34 cases of uncomplicated first or second attacks of coronary thrombosis, reporting a total of 80. This series has since become considerably larger. The deaths in the series amounted to 15, but considering the fact that the cases were selected because they were extremely ill, as will be illustrated, that is not a high death rate. One individual was an army major who had an anterior infarction. On the 12th day he had a posterior infarction, and on the 19th day evidence of extension of his posterior infarction. He was then given dicumarol for 30 days; there were no further episodes. He had uneventful recovery. Another army officer had an anterior infarction. On the 8th day he had an embolism to the right femoral artery, on the 10th day an embolism to the left femoral artery, on the 12th day a cerebral embolism. It is very important to know how to treat these embolic accidents locally to get the best results from the viewpoint of the extremity, but it is even more important to interrupt the process so that they are not repeated. This patient was treated with dicumarol. He had no further episodes or emboli and he made a recovery except for claudication in his right leg and with a scarred heart. He was retired from the army in not too bad condition. A third woman patient was 68 years old. She had hypertension, diabetes, gall bladder disease and she suffered a septal infarction, developing auricular fibrillation. On the 28th day she had an embolism in the right femoral artery. On the 31st day she had a cerebral embolism with hemiparesis and aphasia. She was in extremis, in an oxygen tent covered with cold sweat, and looked as though she would not survive. Dicumarol was started and she received it for 18 days. No further emboli occurred. We stopped the dicumarol because her right leg became necrotic and was amputated four days afterward. She made an uneventful recovery. Fifteen months later she is at home. She is living a quiet but satisfactory life, riding in a car and occasionally going to the movies. She is still fibrillating, and, of course, she still has her diabetes, but she recovered from what appeared to be a very serious cycle of events. Another patient had an anterior infarction. On the 6th day he started to have pulmonary emboli. He had pain in the right lateral chest, with bloody sputum. An auricular fibrillation developed and on the 7th day, pain in the left base with a similar episode on the 9th day in the right middle lung field. Dicumarol was started. There were no further emboli but he had a progressively downhill course with death on the 30th day, after 21 days of dicumarol. This was due to the fact that he had developed extreme congestive failure. He had multiple infarctions but none had apparently occurred within two weeks of death, (or later than one week after he started anticoagulant therapy). He had a large thrombus involving the right coronary artery, blocking several large branches and his myocardium in that area was infarcted. It was very necrotic. One could put one's thumb through it very easily. An interesting finding was a large mural thrombus which was olive-shaped. It was apparently a recent thrombus but very neatly sealed over with a layer of fibrin and apparently incapable of giving off any more emboli. His veins were searched for the possibility that the emboli might have come from venous sources, but we could find no source. In reviewing this group of cases I think we can say that dicumarol has not aggravated the condition. It appears physiologically sound to use anticoagulants when there is a tendency for propagation of the thrombus or when multiple thrombi tend to form in the coronary artery or elsewhere, or where there are emboli. The thrombo-embolic processes appear to have been interrupted. No evidence has been produced that the thromb

ave been dissolved once they are formed. Progres- on of established infarctions is not interrupted by icumarol. The rate and rhythm of the heart is not irectly affected by dicumarol. The risk of future ttacks after dicumarol is discontinued is apparently nchanged. This is preliminary work and the results re similar to those of Nichol and Page, and Bram- el, Peters, Guyther. All reports based on sufficient xperience to warrant a preliminary expression of pinion. These have been favorable but the total mount of work was still inadequate and the cases ot well controlled. For this reason, under the uspices of the American Heart Association, and vith the financial assistance of the United States ublic Health Administration a study is being arried out involving seventeen hospitals through- ut the country in which alternate case methods are eing used. Under the circumstances, after a thou- nd cases have been studied, we should have a true valuation of the problem. The results appear favor- ble, but the total number of cases is thus far in- dequate to permit final conclusions, or the release f figures.

There is one additional group of cases that fall nto this general category of thrombo-embolic prob- ms which we have been studying. This study is at resent in a more preliminary state than the last. hese are individuals who had had rheumatic fever arly in life, who have developed thrombi in their uricles or auricular appendages, if you will, and who hereafter have had a series of emboli. As all physi- ians know, these people are among the most tragic ve have in medicine. They are sitting under the word of Damocles at all times, never knowing vhen they are going to have another embolus and vhat it is going to do to them. Several cases of this ature will be cited in order to indicate a method of pproach to the problem. The first is a patient 53 ears of age. She had rheumatic fever at 28 years f age followed by five recurrences. She developed uricular fibrillation five years ago, and it has re- urred periodically since. Emboli were recognized s follows: in May, 1944, a cerebral embolus, in May, 1946, a sudden blackout, probably cerebral; n June, 1946, she had emboli to both legs, and on uly 7 she had one to the right hip and one to the ungs, on July 14 one to the right leg. She was not tarted immediately on anticoagulant therapy. Later licumarol was started in the hope of preventing urther emboli. It was given for one month under ontrolled conditions in the hospital. Since then she has been ambulatory, and has had no further emboli. She has had one complication which should be mentioned. At 53 she suddenly developed excessive flow for ten days, although her prothrombin time was 28. Dicumarol was discontinued, vitamin K was given. She had a dilatation and curettage, and radiation, and has since been started on dicumarol again, with no further complications or emboli. The second case represents a more serious problem. She had typhoid at three, scarlet fever at four, rheumatic fever at five; rheumatic heart disease was recognized at six years of age. She had chorea at six, ten and twelve years. Since she was 33 years of age, or for 14 years, she has been on digitalis and has been fibrillating. In 1935 she started to have emboli. The first was to the left leg, one in 1936 was to the left loin, another to the lungs. An interesting observa- tion that has been impressive in this series is that, contrary to common medical opinion, most patients who have had a number of emboli have had them from both sides of the heart. In other words, they have had both pulmonary and peripheral emboli. In 1942 she had a left cerebral embolus with right hemiplegia. In 1943 and 1944 she suffered five more in various locations. These were in gen- eral rather small. The 11th and 12th important emboli occurred in December, 1945; one was renal, the other was mesenteric, the 13th in January 1946, the 14th in September, 1946. She became decompen- sated on November 15, 1946, and the 15th embolus occurred on November 17 to the right arm; the next ones struck on November 19 to the left leg, and November 25 to the right lung. December 3 she had one to the abdomen, in the right lower quad- rant, with shock, paralytic ileus, and later blood in the stool. On December 3 she had another one to the left leg. Her 20th occurred on December 6 to the right forearm at which time she went into shock. On December 6 she was first seen by us and was placed on heparin and dicumarol therapy, receiving 52.5 mg. of heparin at 9 P. M., 1 A. M. and 6:15 A. M., together with 300 mg. of dicumerol in spite of the fact that she had blood in her stools, on the basis that it was an embolic problem and she was in such desperate condition that we had to take some risk. She was given hospital treatment for one month. She averaged 100 mg. of dicumarol five times weekly and has been ambulatory since. In January 18 she had a few ecchymoses. Her pro- thrombin time at that time was 44 seconds, a little bit higher than we like to have it for ambulatory

treatment (optimal 25-35 seconds). Aside from that, with the exception of occasional ecchymoses, she has done remarkably well. She travels; she came into the New York Hospital from Westchester for a clinic by herself. She is in very fine spirits and feels remarkably well. She had nine emboli within several weeks before she started anticoagulant therapy but there was a prompt cessation of this syndrome beginning the day she started it with no recurrence since (December 6, 1946). One more patient will be described—this woman had rheumatic fever at four years. She is now 38. She had multiple attacks and developed a heart lesion before she was 12 years of age. In 1941 auricular fibrillation and mitral stenosis with decompensation was recognized. In 1946, in February, she had a saddle embolus. She was given heparin for two weeks at that time. The embolus apparently divided and segments went down to both legs, blocking the popliteal arteries but permitting sufficient collateral for survival. In 1946 also, from between February and June, she had six other embolic episodes involving the legs, the abdomen and the brain. In September 1946, she had an embolus to the right foot. She also had additional emboli to both legs. On November 2, the day we first saw her, she had a cerebral embolus with dizziness, diplopia, slurring of speech, involuntary twitching of the right arm, occipital headaches, and lack of conversion to the right eye. November 3 she was started on dicumarol. This was given for one month in the hospital. She has been ambulatory since. There have been no further emboli. The total series at present is small. We now have twelve patients who have been followed. One patient has died. This individual was unable to continue ambulatory treatment at home and we feared that she would get into serious difficulty. She had had many emboli before and she recently re-entered the hospital, having had the serious complication of emboli plus hemorrhage, and died. The other eleven have now run a total period of 65 months under ant coagulant therapy with no emboli. Thus far this presented as an approach, the like of which has n been made in the care of these very desperately patients. In order to make this technique work ce tain criteria must be fulfilled. One requirement is very intelligent patient who is willing to coopera completely with the doctor. The second is a fir class laboratory so that the patient can get pr thrombin levels taken accurately and frequentl enough to control the case. One of the questio which always arises is how often the prothromb level should be determined on an ambulato patient. We determine it daily for the first mon until the need, or the toleration of the patient f the drug is demonstrated. Some patients do ve well on an average of 50 mg. a day. Other patien require 100 mg. a day, and we now have a patie who requires 200 mg. a day. Therefore the requir ments must be very carefully determined before t patient is discharged from the hospital. It is th possible to decrease the frequency of prothromb determinations from once a day to three times week, then twice a week, later once a week. We d not recommend greater intervals.

In reference to the effects of long-term dosag Dr. Sterling Nichol has a patient who has be taking dicumarol for approximately four years wit no ascertainable liver damage. We have a number patients who have taken dicumarol for more than year without evidence of liver damage, so this que tion appears to be approaching answer. For the latter patients there appears no alternative but pe manent ambulatory treatment, at least for lon periods of time. For the serious coronary cases, on that have had three or four or more episodes, th may also be the final choice. These studies, in relatio to the use of anticoagulants in heart disease must b considered as early, and not as yet conclusive, but th results to date are interesting and worthy of furth investigation.

CLINOPATHOLICAL CONFERENCE

by The Waterbury Hospital Staff

Joseph O. Collins, m.d., Editor, *Waterbury*

Case presentation by the intern

This is the history of a child who had repeated hospital admissions between the ages of four and seven, with a final admission at the age of eight years, when he died in the hospital. The child was said to have been born six weeks prematurely, but weighed six pounds at birth. There was nothing of note in the neonatal period. At six weeks, the child weighed 6 lbs., 2 oz., but appeared pale. In infancy, the child cried excessively at night, and was always jumpy. He sat up at six and one half months, walked at thirteen months, talked at thirteen months, first tooth at eight months. Small stature was first noticed by mother at about five years, when the child was thought to be about the size of a three-year-old. He began kindergarten at five years. He had measles, grippe, tonsillitis, and otitis media at about two years. He cried when voiding for several weeks after grippe. The child had chickenpox at three years, whooping cough at four years. He had frequent epistaxis. At the age of four, the child complained of pain in the lower right flank with anorexia, lassitude, afternoon fever, some nausea, diarrhea, dysuria, frequency, burning and incontinence. The child appeared pale. There was no sharply marked acute phase; symptoms diminished slowly in severity. Various physicians were consulted who found pyuria and advised urinary antiseptics, alkali and iron.

Two months later, the child was admitted to St. Mary's Hospital where he showed low grade fever, acid urine with specific gravity of 1.004 to 1.010, and a 3 plus albumin and much pus. Blood picture was essentially normal, NPN was 60. An I. V. skiodan showed poor visualization of a large bladder; no stone was found. On cystoscopic exam, the bladder mucosa was dull red. There was no ulceration, no diverticula, and no obstruction. The pyelogram showed large, tortuous ureters and a dilated right pelvis.

The child was seen by a physician a year later when he appeared small, very poorly nourished, with moderate knock-knee. A right abdominal mass thought to be a large right kidney was palpated. There was no fever at this time. Urine was acid, containing much pus and albumin. His weight was 31½ lbs., length 36½ inches; average normal for that age being weight 39 lbs., length 42 inches. Pyuria continued with occasional brief fever and some dysuria.

Two years later, there was an episode marked by fever, vomiting, diarrhea, cramps in the extremities with twitching at night, and some epistaxis. The patient was then admitted to the Waterbury Hospital.

Primary admission to Waterbury Hospital

Present Illness: The patient was first admitted to the hospital in August 1936, at the age of seven years, complaining of cough, labored breathing, vague aches and pains, and hyperesthesia with some muscle cramps. The onset of this attack occurred ten days before admission when cough developed. Four days later the respirations became labored, deep, and rapid, and have become continually worse since that time. He has had several nose bleeds, and it was stated that occasionally he discharged blood clots when blowing his nose. He had headaches during this period but there was no fever. There were cramps in the hands, shoulders, legs, and feet, with hyperesthesia, burning and irritation of the glans penis, and diarrhea for two days. The child was quite toxic and irritable.

Physical Examination: Upon P. E., he appeared pale and hyperpneic. B.P. was 118/82. He was under-developed and under-nourished. Chondrocostal junctions of the ribs were prominent. Abdomen could not be examined satisfactorily because of abdominal tenderness. This may have been explained by the fact that the patient had just had an hypodermoclysis in the abdominal wall prior to

examination. The lower extremities showed moderate genu valgum and club foot.

X-rays: An x-ray examination showed expansion and cupping of the ends of the long bones, especially marked on the lower ends of both radii and ulnae, and the lower ends of the tibiae and fibulae. A peculiar punched-out area was seen in the diaphysis of the upper end of both tibiae. There was marked widening of the epiphyseal line for the heads of the femurs. The lower half of the sacro-iliac joint was widened.

I. V. skiodan failed to visualize the kidney pelvis on either side.

Injection of opaque material into the bladder failed to visualize the ureters, even when the bladder was distended well above the umbilicus.

Cystoscopic Exam: A cystoscopic examination ruled out obstruction of the urethra. The left ureteral orifice was wide and gaping. The right orifice was within normal limits. Catheters were readily passed on each side. Pyelograms, then taken, showed the catheters to be curled-up in the lower portion of each ureter. Each ureter was widely dilated. The pelves were not demonstrated.

A subsequent retrograde pyelogram on the left showed a dilated left ureter and pelvis.

Lab. Data: Blood chemistry showed an NPN of 90, calcium 7.1, creatinine 2.2, phosphorus 6.2, chlorides 500, CO_2 combining power 23 per cent, cholesterol 200, total protein 6.7, albumin 5.6, and globulin 1.1. Blood count revealed RBC 3.9, WBC 6,000 with 50 per cent polys. A urinalysis showed 2 plus albumin and myriads of pus cells.

Treatment: Treatment consisted of blood transfusion, fluids ad lib, calcium acetate, sodium bicarbonate, I. V. fluids with glucose. A tuberculin test was negative.

The patient was discharged considerably improved after three weeks in the hospital. The child was kept on calcium acetate and sodium bicarbonate, by mouth, and seemed to do well on this regime.

SECOND ADMISSION

Patient was readmitted to the hospital for observation six months later. He apeared cheerful and comfortable.

X-rays: X-rays of the skeleton were essentially similar to those reported.

Lab. Data: Blood count revealed hgb 80 per cent, RBC 3,390,000, WBC 6,150, with a normal differential count. A Mosenthal test showed a fixed specific gravity of 1.008, 1.009, in all specimens, all contained pus. A blood chemistry at this time showed sugar of 12.5 mg. per 100 cc., NPN 73.7, uric acid 5.2, calcium 9, creatinine 3.4, phosphorus 4.6, chlorides 560, CO_2 combining powers 38.5, total protein 3.9, cholesterol 210 mg. A PSP test showed no return of dye in two hours.

The patient was discharged home on the same regime as before with the addition of increased protein intake, and the addition of biosterol.

SUBSEQUENT ADMISSIONS

During the following year, the patient had three additional hospital admissions with findings similar to those on previous admissions.

FINAL ADMISSION

(Age eight years.)

Patient had been fairly well up until eight days before this admission at which time he developed a nasal discharge and cough. There was some epistaxis. There was considerable anorexia and starting the day before admission, patient became hyperpneic and this symptom became progressively worse, until admission.

Physical Examination: P. E. showed temperature 98, plus 100, respirations 36. Patient appeared anemic, poorly nourished and under-developed. Chest was clear, heart negative. Abdomen slightly distended. There was marked genu valgum.

Lab.: Bleeding and clotting time were normal. Blood count showed Hgb. of 36 per cent, RBC 2.5, WBC 10,500 with 72 per cent polys. Urine showed much albumin and many pus cells. CO_2 combining power 11.7, sugar not done. NPN was 180 mg., uric acid 6.1, calcium 9.3, phosphorus 5.2. Two days later NPN was 225, uric acid 10, creatinine 5.

Treatment: Patient was given Hartmann's solution and glucose and saline I. V. but progress was rapidly downhill and he died on the third hospital day.

DIFFERENTIAL DIAGNOSIS

Dr. Paul Teiger: This picture was one characterized by an insidious onset. The first inkling that there was anything wrong occurred six weeks after birth when the infant gained only two ounces in six weeks and appeared pale. The rest of the period of infancy was not unusual.

At two years of age the child had "grippe" for several weeks and cried when voiding. One wonders whether a check-up of the urine was done and what it would have shown.

At the age of four years definite urinary symptoms were manifested by pain in the right lower flank, dysuria, frequency, burning, incontinence with nausea, anorexia, lassitude and fever. Treated for two months with urinary antiseptics and supportive therapy, no improvement was noted and the child was admitted to St. Mary's Hospital. Here a full blown picture of severe renal damage was noted. Poor kidney function was manifested by concentration of the urine from 1.004 to 1.010, albuminuria and pyuria. Investigation of the kidneys showed large tortuous ureters and a dilated right pelvis which was in keeping with the large mass palpated on the right side.

Small stature was noted as well as poor nourishment and knock-knees; fever and pyuria persisted.

At the age of seven, there was an episode marked by fever, vomiting, diarrhea, cramps in the extremities and epistaxis. The child had labored breathing and a cough. These symptoms may have been due to pneumonia. However, the muscle cramps and twitchings were probably due to tetany, since there was a low calcium and a high phosphorus. A severe uremic picture was noted; the NPN being 90. Acidosis was evident by a CO_2 combining power of 23 per cent. X-ray of the long bones showed a rachitic picture as well as osteoporosis shown by the peculiar punched out portions seen in the tibiae. By x-ray examinations the ureters were shown to be dilated. The blood pressure was increased to 118/82 (normal is about 90/60). This may have accounted for the nosebleeds.

Deformities were noted as shown by club feet, beading of the ribs and genu valgum.

Subsequent admissions showed increasing uremia, fixed specific gravity, lowering of the total protein and PSP of O. At the age of eight the child died of uremia.

This is a picture of renal rickets. Other names for this condition are Renal Osteitis Fibrosa, Cystica, Renal Dwarfism, Renal Infantilism and Renal Hyperparathyroidism with Osteoporosis (Osteitis), Fibrosa Cystica. The latter is perhaps the most exact designation.

The pathology of this condition in the majority of instances is found to be developmental and consists of either congenital valves of the urethra situated in the vesicle outlet (in boys) or strictures of the ureter or some other condition which obstructs the outflow of urine and creates resistance which causes hydroureter and hydronephrosis, interferes with the normal development of the kidneys and causes them to undergo atrophy. With obstructions of this kind infection is also usually present. The most common infecting organism is the colon bacillus. The damage to the kidneys is, under these circumstances, the combined results of the defective development in the urinary tract and the infection. Similar pictures have been shown with polycystic kidneys and in one case of acute glomerular nephritis.

The most common sequence of events must be as follows: The obstruction has caused a hydronephrosis and some atrophy of renal tissue. An ascending infection then sets in from which the body, hampered by the obstruction to the outflow of urine, can not free itself, with the ultimate result that large parts of the functioning substance of the kidneys are destroyed. The proximity to each other of the scars of the glomeruli tell the extent of collapse of renal tissue. If infection alone is the cause it has been present at least for months, more likely for years, and the weight gross and microscopic appearances of the kidneys all indicate that large numbers of glomeruli and tubules have been destroyed.

The low blood calcium according to Albright stimulate the parathyroids to hypertrophy. This hypertrophy in turn is thought to be the cause of the rickets and osteoporosis.

In this case there was x-ray evidence of large tortuous ureters and a dilated right pelvis at the age of four years and a subsequent retrograde pyelogram showed a dilated left pelvis.

Cystoscopic examinations at the age of four revealed no obstructions. At the age of seven the left ureteral orifice was wide and gaping, the right was within normal limits. Catheters could be readily passed but were curled in the lower portion of each ureter and the pelves were not demonstrated.

One wonders then whether the original pathology was not a bilateral stricture in the mid-ureter region with subsequent hydroureter, hydropelvis followed by infection causing the pyuria which was a constant feature.Whether early surgery together with the administration of sulfadiazine, penicillin and streptomycin which were not available in 1937 might have saved this child, is problematical.

Finally the following diagnosis is offered in this case—Renal Hyperparathyroidism with Osteoporosis (Osteitis) Fibrosa Cystica following congenital strictures probably in the mid-ureter region.

CLINICAL DIAGNOSIS

1. Renal rickets.
2. Congenital hydronephrosis.

Dr. Teiger's diagnosis

1. Congenital strictures of the ureters.
2. Renal hyperparathyroidism with osteoporosis fibrosa cystica.

PATHOLOGICAL DIAGNOSIS

1. Bilateral pyonephrosis.
2. Bilateral hydroureter.
3. Renal rickets.

PATHOLOGICAL DISCUSSION

Dr. Collins: Dr. Teiger is correct in his diagnosis of renal rickets. Autopsy was limited to the abdomen. The bladder wall showed no abnormal thickening or trabeculation. It contained a few cc. of cloudy urine. No obstruction of the bladder neck or urethra could be demonstrated. Both ureters and both kidneys were markedly dilated and filled with thin watery urine. No congenital valves, abnormally placed vessels or other obstructing anatomic structures were found to explain the marked hydroureter and hydronephrosis. We were tempted to draw an analogy between the kidney lesions and congenital megacolon based on a faulty neuromuscular mechanism, but could bring no objective evidence to bear in support of such an analogy.

With regard to the decalcification of the skeleton in renal rickets, several possibilities seem worthy of mention. To begin with, elimination of phosphate by the kidney is impaired with resultant phosphorus retention as indicated by high serum phosphorus. At the same time excessive amounts of phosphorus are poured into g.i. tract for elimination with the stools and this high concentration of phosphorus in the intestine interferes with absorption of calcium from the diet, calcium in the blood becomes depressed below the normal level. The parathyroid glands, being charged with the duty of maintaining a normal serum calcium become hyperactive to bring about mobilization of skeletal calcium which is picked up by the blood. The process results in decalcification of the skeleton in a manner similar to that observed in primary hyperparathyrodism. At times the parathyroid activity seems to be in excess of what is required and high serum calcium values may sometimes be observed with consequent excessive loss in the stools. Under such circumstances the parathyroids are frequently found to be much hypertrophied. Because of the limited autopsy permit we were unable to investigate the parathyroids in this case.

CLINICAL OBSERVATIONS ON THE USE OF ANTI-THYROID DRUGS

A Review of the Current Literature and a Report of 60 Cases Treated at the Hartford Hospital

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THE ROLE of thiouracil and related compounds as antithyrotoxic agents has been under close scrutiny since 1943. The release of the most effective of these agents (6 n. propylthiouracil) has been withheld until August, 1947, primarily because of the toxic side effects which its progenitor, thiouracil, had produced. Data is now accumulating indicating the relative freedom from these toxic reactions in the use of propylthiouracil.

The early investigations of Astwood and Vander Laan[1] showed that, of the many compounds goitrogenically potent, 6 n. propylthiouracil, as tested in rats, was ten times as active as thiouracil, and that the former exerted a more lasting effect following a single dose since it was eliminated more slowly from the body. It was also observed that propylthiouracil possessed the therapeutic advantage of a greater activity-toxicity ratio: i.e., that, while more toxic than thiouracil on a weight basis, propylthiouracil was considerably less toxic when administered in quantities calculated on the basis of equivalent antithyroid effect.

In a comparative study of the effectiveness of the two agents, Beierwaltes and Sturgis[2] have shown that the rate of descent of the B.M.R. in conjunction with corresponding improvement in subjective symptoms were identical. The rapidity of reduction in the B.M.R. has been calculated by several investigations, and the conclusions show a descent of roughly 1 per cent every one or two days of treatment.

Opinion regarding the amount of the initial and maintenance doses of propylthiouracil favors higher doses than were originally felt to be safe. In the report of 100 cases treated by Astwood and Vander Laan,[3] 57 per cent of the patients were controlled on 75 mgm. or less daily. The remaining 43 per cent, doses of 100 to 150 mgm. were given initially or were required later to restore metabolic equilibrium. McGavach et al.[4] have employed higher initial doses ranging up to 250 mgm. for a predetermined limited time not exceeding 7 days. More recently, verbal reports have indicated that doses as high as 300 mgm. are necessary in selected cases.

Previous iodine therapy seems to definitely retard the response to antithyroid compounds.[3] However, the use of iodine concomitantly with those agents or later in the course of treatment seems to have an additive effect.[6]

Toxic adenomata and psychogenic conditions have likewise been shown to be entities in which the response to these agents has been retarded.[3] In these instances, larger doses of propylthiouracil are required.

Beierwaltes and Sturgis[2] emphasized that bed rest enhanced the initial response of the thyrotoxic state, although the eventual result was the same when patients were treated ambulatory throughout.

There are no absolute criteria for establishing the minimal effective maintenance dose of propylthiouracil. Careful observation of each patient for the appearance of the manifestations of myxedema, such as lethargy, sluggishness, excessive gain in weight, puffy face, thyroid enlargement, a high cholesterol and a low B.M.R. or the converse, indications of return of toxic signs and symptoms, seem to be the best available indices for judging the maintenance dose. Astwood[3] was of the opinion that myxedema seldom occurred with a maintenance dose of 25 to 50 mgm. of propylthiouracil daily. He also pointed out that the adequate interpretation of the minimal dose was complicated by the fact that the majority of patients undergo a complete remission sometime during the maintenance period and no longer require therapy. He stated that were this not recognized, small doses might be credited as being responsible for continued health.

McGavach et al[4] felt that remissions could be avoided by gradually reducing the dose of propylthiouracil. After the patient had received a maintenance dose for three months or more, the dose was decreased by 25 mgm. daily at each monthly visit until the patient had been maintained for one month on a single tablet of 25 mgm. daily. For an additional month, 25 mgm. was administered every other day. The drug was then stopped if metabolic equilibrium had been achieved. On this regimen, 10 of the 75 cases followed had no recurrence of thyrotoxic symptoms four months after discontinuing the drug. This, of course, is not an adequately long follow-up from which to make definite conclusions. Other more pessimistic estimates are that 50 per cent of all patients will have recurrence after discontinuing propylthiouracil.[5]

In Bartels'[7] series of 21 cases treated with thiouracil, 32 per cent remained in remission, and 62 per cent had a relapse after cessation of therapy. He showed that the duration of thiouracil administration after restoring the B.M.R. to normal was not a factor in determining the duration of the remission in that prolonged remissions occurred after short term therapy, and prompt relapse was observed after long term therapy.

Side effects from propylthiouracil, in general, coincide in comparing various reports. They range from drowsiness, generalized pruritis, an acneform eruption, headache, nausea, sore throat, vertigo, and leukopenia. In a summary of 284 individual case reports compiled by Lederle[8] 5.9 per cent showed toxic effects treated with propylthiouracil. The drug was discontinued in 1.4 per cent of these. One case of non fatal agranulocytosis was reported to Lederle by Dr. Bartels. No deaths have been reported to date from the use of propylthiouracil.

The lack of toxicity of propylthiouracil as compared to thiouracil was felt to be largely by virtue of its lower dosage and not to an allergic response by the individual. The more severe reactions such as agranulocytosis, drug fever, etc., may, however, be logically expected if the dose of propylthiouracil is increased.

The use of propylthiouracil seems to be the drug of choice at the present time in the following conditions: (1) Toxicity in the small, diffuse, hyper-

Table I

Summary of 47 Individual Case Reports of Patients Treated Exclusively by Thiouracil or Propylthiouracil at the Hartford Hospital

	THIOURACIL		PROPYLTHIOURACIL	
	NUMBER	PERCENT	NUMBER	PERCENT
Patients treated for thyrotoxicosis	10	21%	30	63%
Number of Toxic Adenoma	2	4%	4	8%
Number of Diffuse Hyperplasia	8	17%	26	55%
Number Improved	8	17%	27	57%
Number Unimproved	4	8%	3	6%
Number of patients showing toxic side effects	1	2%	0	0%
Type of Toxic Reaction				
Agranulocytosis		1		0
Number of deaths		0		0
Average daily dose		0.3 gms. (300 mgm)		75 mgm.
Average time for subjective improvement		3.6 wks.		2.7 wks.
Average time for B.M.R. to reach normal		6.0 wks.		6.5 wks.
			NUMBER	IMPROVED
Patients treated for miscellaneous causes		Total	7	
Hypertensive cardiovascular disease			3	1
Pheochromocytoma			1	0
Hodgkins Disease			1	0
Menopausal syndrome			1	0
Thyroiditis			1	0

Table II

Summary of 13 Individual Case Reports of Patients Treated with Thiouracil or Propylthiouracil Preoperatively at the Hartford Hospital

	THIOURACIL		PROPYLTHIOURACIL	
	NUMBER	PERCENT	NUMBER	PERCENT
Total number of patients treated	5	38%	8	61%
Diffuse hyperplasia	5	38%	7	54%
Toxic adenoma	0		1	7%
Average daily dose	0.35 gms. (350 mgm)		100 mgm.	
Average time for subjective improvement	3.5 wks.		1.4 wks.	
Average time for B.M.R. to reach normal	6 wks.		6.5 wks.	
Average duration of preoperative treatment	7.5 wks.		11 wks.	
Average length of hospital course	9 days		10.8 days	
Number of toxic reactions	0	0%	0	0%
Number of operative complications (excessive hemorrhage)	0	0%	2	25%
Number improved	4	80%	8	100%
Number unimproved	0		0	0%
Number of deaths	0		0	0%
Number of recurrences	0	0%	0	0%

plastic gland in its early phase. Early remissions may be expected in these cases. (2) The so-called apathetic hyperthyroidism described by Lahey,[9] a condition occurring in the elderly individual showing no eye signs, no activation, no enlargement of the gland and with only moderate tachycardia but particularly associated with definite weight loss and definite myasthenia over a long period, and frequently associated with only moderate elevation in the B.M. R. (3) Those patients in whom surgery is contraindicated for whatever reason.

Lahey[9] has emphasized the contribution which the antithyroid drugs have made in surgery of the thyroid gland. In 500 cases preoperatively prepared

by these agents, he has shown a reduction in patient mortality from 0.25 per cent to 0.17 per cent. Furthermore, he was able to abandon multiple stage operations thereby decreasing the hospital stay from fifty-five days in patients prepared with iodine alone, requiring a three stage operation, and thirty-five days in patients requiring a two stage operation, to eight days in patients prepared by thiouracil or propylthiouracil.

The experience to date with the use of thiouracil and propylthiouracil at the Hartford Hospital has been summarized in Tables I and II where the most pertinent data have been tabulated for those treated medically and surgically.

In the medically treated group with thiouracil, the usual recommended dose schedule was followed: i.e., 0.6 gm. initially with a maintenance dose averaging 0.3 gm. The response to this treatment coincided with similar experiences of others investigating this drug in larger series. The four cases which showed no improvement included the only toxic reaction in the entire group, and three others who discontinued treatment voluntarily. The one toxic reaction was one of agranulocytosis with clinical findings of fever, toxicity, and ulcerative pharyngeal lesions which responded to penicillin therapy. This patient subsequently was prepared for operation with iodine and had a successful sub-total thyroidectomy.

Propylthiouracil subsequently replaced thiouracil, and its application in those cases presenting unequivocal evidence of thyrotoxicosis has been eminently satisfactory. The customary dose schedule has been an initial dose of 200 mgm. prescribed as 50 mgm. tablets, 4 i.d. This was gradually reduced usually over a period of a month as clinical improvement became evident. An average maintenance dose of 75 mgm. daily was considered adequate. Two cases were refractory to 300 mgm. daily for over a period of a month, but underlying severe psychogenic factors were suspected in both. Treatment was still being maintained at this writing. In the third case showing no improvement, there was considerable doubt concerning the accuracy of the diagnosis.

It appeared that definite subjective improvement occurred on an average of 2.7 weeks—however, many noted slight improvement before this time. This was in contrast to the lack of support from the laboratory data where considerable lag occurred; to take the B.M.R., as a single example, a baseline reading was not obtained, on an average, for 3.8 weeks after the last symptoms had disappeared.

Laboratory work was held at a minimum. White counts and differential determinations were done every two weeks for two months, then once monthly. The incidence of leukopenia which developed during treatment, but did not necessitate discontinuing the drug, was 8 per cent. In eleven cases, or 18 per cent, a leukopenia was present before the drug was started, and the white counts did not change appreciably during therapy.

B.M.R.'s were done at monthly intervals until they reached normal limits. With the patients on maintenance doses and showing no symptoms of hypo -or hypermetabolism, further determinations were not considered necessary.

Relapse of the thyrotoxicosis following cessation of treatment occurred within one month in two cases treated with thiouracil. However, the resumption of therapy was successful in each instance. Two cases treated with thiouracil for periods of two years have remained in remission without the drug for one year. Two cases treated with propylthiouracil for a period of one year have been in remission for four months without the drug.

There was only one instance where a noticeable increase in the size of the thyroid gland occurred under propylthiourcail. This patient was prepared with Lugol's solution for three weeks preoperatively, and although the gland seemed to involute clinically, surgical removal was met with considerable hemorrhage.

No patient with a known toxic adenoma was recommended for medical therapy with propylthiouracil. Those cases so treated were informed regarding the potential dangers and were given the drug because they refused operation.

The use of propylthiouracil as an agent in the differential diagnosis of hyperthyroidism was found to be of much assistance. In one case of proven pheochromocytoma, with signs and symptoms of hyperthyroidism, there was no response to propylthiouracil, thus leading us to suspect an adrenal medullary tumor.

A case of unsuspected Hodgkins disease of the mediastinum who had an enlarged thyroid gland, elevated B.M.R. and other signs and symptoms pointing to thyrotoxicosis was treated unsuccessfully with propylthiouracil. Subsequent examinations revealed the true etiology.

In several patients with menopausal syndrome and associated anxiety and emotional lability, the use of the drug aided us in eliminating the thyroid gland as an etiologic agent. In one case of hypertension on an arteriosclerotic basis, with mild failure, prolonged use of propylthiouracil seemed to produce a very desirable effect.

We were impressed by the display in many patients of a strong psychosomatic imbalance which blocked the usual response to the antithyroid agents until the precipitating factors could be eliminated by simple psychotherapy. We are convinced that the practice of psychosomatic medicine will find a fruitful field in thyrotoxicosis whether specific therapy is to be surgical or medical.

The thirteen patients treated surgically were prepared with antithyroid drugs at the pleasure of the surgeon. The preoperative course and response to therapy followed the usual trend. Patients were given Lugol's solution three weeks prior to operation. Technical difficulties such as excess bleeding and tissue friability were encountered in two cases. The remaining eleven cases did not present problems worthy of note. The hospital course varied between nine to ten days, and the postoperative convalescence was uneventful in all instances.

The philosophy which we have adopted in surveying the use of antithyroid drugs has been a broad one in view of the limited number of cases. It can be summarized as follows:

1. Surgery, at the present time, is the treatment of choice for the majority of patients with thyrotoxicosis.

2. Surgery is recommended for those patients with:

a. Toxicity of short duration with moderately large, diffuse, hyperplastic glands.

b. Toxicity of any duration with single or multiple adenomata.

c. Recurrent thyrotoxicosis with thyroid enlargement.

3. The drug of choice for preoperative preparation is usually left to the discretion of the surgeon:

a. Iodine alone is beneficial and effective in the many cases of mild to moderate activity.

b. Propylthiouracil is the agent of choice when the patient shows evidence of severe thyrotoxicosis in any of its manifestations: i.e., in elderly patients with thyrocardiac disease, myasthenia, malnutrition, etc., or in those who, because of economic reasons cannot afford to abandon their means of livelihood at once.

c. When propylthiouracil is used, iodine is administered three weeks prior to the date of operation in the usual dose, and propylthiouracil is omitted two weeks prior to operation after the B.M.R. has been found to be within normal limits.

4. Medical treatment with propylthiouracil alone is recommended in those patients with:

a. Small, diffuse, hyperplastic glands, in whom symptoms are of short duration.

b. Those few patients in whom surgery is contraindicated because of complications either due to or coexistent with the toxic thyroid.

c. The elderly patient with the apathetic type of hyperthyroidism.

d. Those who, either because of financial or psychogenic reasons, are not sufficiently prepared for operation.

5. Psychotherapeutic treatment, we believe, plays an important role in the results whether patients are to be treated surgically or medically. Propylthiouracil, therefore, has proven an excellent adjunct in assisting the investigation of this phase of the disease which has been a primary factor in thwarting successful specific therapy and in precipating recurrence of symptoms.

6. Propylthiouracil, as an agent in differentiating other clinical syndromes simulating thyrotoxicosis has become a useful and safe tool—if not used indiscriminately.

BIBLIOGRAPHY

1. Astwood, E. B., and VanderLaan, W. P.: J. Clin. Endocrinology, 5:424, 1945.

2. Beierwaltes, W. H., and Sturgis, C. C.: J. Lab. and Clin. Med., 32:392, 1947.

3. Astwood, E. B., and VanderLaan, W. P.: Ann. of Int. Med., 25:813, 1946.

4. McGavach, T. H., Gerl, A. J., Vogel, M.: Amer. J. of Med., 2:144, 1947.

5. Rose, Edward: Clinical Congress of the Conn. State Med. Soc., 1947.

6. Danowski, T. S., Man, E. B., Winkler, A. W.: J. Clin. Invest. 25:597, 1946.

7. Bartels, E. C.: Am. J. of Med., 2:150, 1947.

8. Lederle Laboratory Report, 1947.

9. Lahey, F. H.: N.E.J.M., 236:46, 1947.

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NEWER ASPECTS OF THE PALLIATIVE TREATMENT OF CANCER

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T HAS been conservatively estimated[1,2] that we are a nation of a half million citizens who are nder treatment for cancer in any one year. It also erges on common knowledge to state that 175,000 eople die annually of this disease. A review of these gures leads one immediately to grasp the fact that ere is a large reservoir of cancer patients in this ation who are unwilling to take advantage of, or nnot be cured by current methods of treatment. his large group, then, becomes a problem for lliative or terminal care. As distressing as this may pear, let us then consider how ill prepared we are cope with this problem. A recent survey by the ational Advisory Cancer Council[3] reveals that the resent day medical school curriculum does not ovide adequate and comprehensive instruction in ncer; also, the care of terminal patient is neglected th in the teaching and practice of medicine. And t cancer continues to rank second as the cause of ath in this nation.

There is, however, sufficient reason to be more peful in considering the palliative care of these tients. It has been justly said that cancer research an abstraction until it serves the people. Within e last decade, experimental and clinical research s made available a variety of agents and methods hich have afforded dramatic relief of pain and stressing symptoms, thus allowing for more comrtable terminal life.

Palliation in the past has all too frequently implied e use of x-ray or radium therapy, limited surgery r purposes of nutrition or relief of obstruction, d the generous administration of opiates. Thus we sualize the average case of "inoperable" gastrotestinal cancer provided with a colostomy, ileostny or gastrostomy (which becomes something of nursing problem), still host to his primary lesion, ceiving increasing doses of opiates for pain, and entually expiring from hemorrhage, inanition or me secondary complication. This dismal clinical cture can be drawn for other varieties of neoplas: disease—the patient with extensive intra-oral cancer, heir to dysphagia, dyspnea and pain; the woman invalided by extensive skeletal metastases from primary breast cancer; and the case of extensive systemic Hodgkin's disease, with pruritus, fever, anemia and dyspnea. Small wonder then that the average family physician has felt inadequate to cope with such a problem, and has tended to rely on the liberal use of opiates and narcotics.

Familiarity with recent advances in the management of these patients should help draw the curtain on many such problems. The application of nitrogen mustard in the treatment of lymphomata and of advanced inoperable lung cancer has opened up a new field of chemotherapy, exciting one's imagination to believe that specific agents for specific tumors may soon be available. Hormones, natural and synthetic, which have escaped the attention of few physicans in the past, are winning a new place in our armamentarium for the treatment of prostatic and breast cancer. With the cessation of hostilities, interest in radioactive isotopes has again been renewed at the prospect of more extensive research with these agents, making more compounds available for therapeutic purposes. A better understanding of the human physiological and biochemical economy coupled with the aid of chemotherapeutic agents, good anesthesia, variety of hemostatic agents and availability of blood and plasma have extended the limits of surgery so that few organs or combination of organs in juxtaposition are beyond the limits of the surgeon's scalpel. These develpoments combined with the use of neurosurgical procedures to block afferent sensory pathways from involved areas, and application of simple principles of psychotherapy can bring about considerable alleviation of pain and suffering.

NITROGEN MUSTARD

The search for a systemic agent with selective lytic action on neoplastic tissue has been pursued for many years with fruitless results. Heptaldehyde bisulphite and biotin, to mention two recent agents, have had no clinical application, though startling

experimental results were claimed for them. However, with the advent of World War II, a series of compounds derived from the pharmacological study of mustard gas (beta chloroethyl sulphide) were studied. It was noted that substituting nitrogen for sulphur eliminated the undesirable physical properties and preserved the cytotoxic effects in this series of compounds called the nitrogen mustards. Furthermore, substituting trivalent nitrogen for divalent sulphur allowed room for a substituent group in the molecule. Thus in aqueous solution, the originally unreactive beta chloroethyl amines will undergo intra molecular cyclization to yield an ethyleneimine group which will react with a variety of biologically important groupings in the body—such as organic phosphates and sulph hydryl, carboxyl, amino and sulphide groups.[4] In addition, the biological effects of the nitrogen mustards on tissue is similar to the effect achieved with x-ray and radium. Further investigation with this series of agents revealed that tissues which undergo the most rapid proliferation and growth are the most susceptible to this drug—notably lymphoid tissue.

Thereupon clinical experimentation was cautiously started in 1942 with methyl-bis (beta chloroethyl) amine hydrochloride and tris (beta chloroethyl) amine hydrochloride upon the lympomata, and generally extended to include Hodgkin's disease, leukemias, polycythemia vera and more recently inoperable pulmonary cancer. A recent official statement[5] supplemented by reports from several investigators[6,7] have summarized the results achieved on a series of several hundred cases. This agent is administered intravenously, with recommended dosage of .1 mgm. per kilogram on four successive days, and may be repeated as often as the state of the hematopoietic system will permit. The toxic effects are (a) local severe cellulitis if the drug escapes into the extravascular tissues at site of injection, (b) varying degrees of nausea, vomiting and anorexia after each injection, (c) damage to hematopoietic system, with lymphopenia followed by a neutropenia, normocytic anemia and occasionally thrombocytopenia with hemorrhagic diathesis.

Encouraging results have been obtained with widespread Hodgkin's disease, where fever, malaise, cough and occasionally pruritus are relieved; hepatomegaly and lymphoadenopathy usually regress rapidly and completely. Furthermore, repeated courses, following recovery of bone marrow, have produced further remissions. It has also been noted that certain cases of Hodgkin's disease, resistant x-ray, have responded favorably to this drug. Sin lar results have been obtained with the lymph sarcomata, chronic lymphatic and myelogeno leukemia, and more recently this agent has pr duced striking palliation in far advanced bronch genic carcinoma, causing some regression of prima lesion, relief of compression of symptoms, allevi tion of cough and dyspnea and occasional resorption of hydrothorax.

In general, however, it should be pointed out th this series of nitrogen mustard compounds is not cure for neoplastic disease; that tumor regressio are temporary and achieved at the risk of dama to hematopoietic function; and, most importar their application should be limited to cases wi widespread systemic disease. X-ray is preferable f early cases with localized disease, or for treatment localized recurrence. X-ray and nitrogen musta may be administered to the same patient eith simultaneously or at varying intervals.

The most significant aspect of the discovery this series of compounds is inherent in their spec ficity for neoplastic and proliferative tissue. Is too much to hope that by changing substitue groups in one of these series of compounds, we ma achieve higher specificity of action with more pe manent clinical regressions? Investigations to th end are being pursued at present in an effort answer this striking challenge.

HORMONES

Hormone therapy has escaped the attention few physicians in the past decade, and since th function and growth of reproductive glands is intimately associated with specific hormones, it w only natural that neoplasms of these glands shou be subjected to experimentation by surgical biochemical castration. Hormone and castrati therapy is well established for metastatic prostat cancer—results achieved by similar procedures f advanced male and female breast cancer have be less spectacular but their occasional palliati triumph recommends them within the limitatio set up by clinical investigators.

Since Huggins' report[8] on the effect of an androgenic procedures on metastatic cancer prostate, a whole body of literature has accumulat confirming, for the most part, the beneficial resu obtained with castration and estrogen therap separately, or with combined castration and estr

gen therapy. Pain relief, decrease in size with occasional disappearance of primary tumor and metastases, improvement in appetite, gain in weight and in some instances relief of paraplegia[9] have been noted sufficiently often to recommend this form of therapy as a routine procedure. A recent summary[10] by the original proponent of this treatment demonstrates that 4 of the original series of 20 patients have survived five years and are free of clinical or laboratory evidence of cancer. However the author is cautious not to interpret curability into this method, but rather stresses the dramatic and prolonged palliation which may be achieved with this simple form of surgical and biochemical castration for advanced metastatic prostatic cancer.

Stimulated by the encouraging results of hormone therapy in advanced prostatic cancer, attention was directed to the favorable clinical reports of Ulrich[11] and Loeser,[12] utilizing male hormone therapy in advanced inoperable carcinoma of the female breast. A small series of patients[13] with this disease were treated with small doses of testosterone proprionate with unfavorable results. These studies, however, were pursued further, and Adair and Hermann[14] demonstrated favorable response in 4 of 11 patients treated with large doses of male hormone. Relief of bone pain, gain in weight and strength, increased calcification of metastatic skeletal foci, and regression of soft parts metastases and the primary breast lesion were noted in the favorable group. Paradoxically enough the estrogens have also been assigned a role in the treatment of advanced female breast cancer. The work of English investigators[15] suggested that the synthetic estrogens had a growth-retarding action on tumors. Of several synthetic estrogens, stilbesterol proved the most efficacious clinically in retarding the growth of the primary breast tumor and soft parts extension. This work has been confirmed by Nathanson,[16,17] who has noted that stilbesterol exerts its best effect on soft tissue disease, both local and metastatic, with only isolated and unpredictable improvement on pulmonary and osseous deposits. Furthermore, estrogen substitution therapy appears to be most effective in women over 60; in younger women, clinical effects with stilbesterol are indifferent and occasionally the disease appears reactivated. Testosterone proprionate, on the other hand, suggests itself as the hormone of choice for patients in the early postmenopausal phase (45-55), especially since bone metastases are so common in this group.

While this paradox of employing both male and female hormone for the same disease may smack of empiricism, let us recall that the breast neoplasm of the premenopausal woman differs histologically and in its clinical behaviour from that of the late menopausal patient; also there is reason to believe that endocrine levels and balance vary similarly.

In the above discussion, we have been dealing essentially with biochemical castration. What of the role of surgical or radiological castration in breast cancer? At regular intervals, since first championed by Schinzinger in 1889, this form of therapy has been proposed. Some have been enthusiastic about radiological castration, while the proponents for surgical castration justify their approach by pointing out the inconstancy of anatomical position of the ovary, the variation in antero-posterior diameter of patients, and lack of data as to the efficacy of x-ray in uniformly ablating hormonal function. A recent survey[18] comparing the efficacy of both methods of castration in female breast cancer finds no appreciable difference in percentage of improvement with either modality—each was attended by improvement in only 15 per cent of those so treated. Routine castration of the premenopausal woman with breast cancer without skeletal metastases would therefore appear to be unwarranted. The presence of skeletal metasases, however, in the premenopausal patient would justify this adjuvant treatment, with expectation of clinical improvement in but a small percentage.

Surgical castration of the male, suffering from advanced breast cancer with skeletal metastases, has been reported[19] to yield rather dramatic palliation, clinically resembling that attending similar treatment for prostatic cancer. In all justification it must be mentioned that male breast cancer is a rare disease, making up about 1 per cent of all breast cancers, and but a small series has been available for study and careful documentation.

SURGERY

That cancer surgery is difficult and has challenged the endeavors of surgeons over the years is apparent and well appreciated. This challenge of the high mortality attending extensive resections has been successfully overcome with the more complete appreciation of electrolyte and water balance, parenteral alimentation, including liberal use of whole blood, improved techniques and personnel

in anesthesiology, increased familiarity with physiology of shock, hemostasis, and respiration and the aid of antibiotics. Pre and post operative care have rightly assumed equal importance with the technical execution of surgical procedures. Suffice it to say that there are few organs that are today inaccessible to the scalpel of the well trained surgeon. The role of palliative surgery is less well defined probably because it is more difficult. It has been pioneered by a few courageous surgeons who have been willing to accept a surgical mortality, where prolonged suffering could not be alleviated by any other means.

Just over a decade ago the patient with cancer of pancreas, duodenum, proximal stomach, esophagus and lung was relegated to the "noli me tangere" group by virtue of the anatomical location of the neoplasm. Malignant growths of maxilla, mandible and anterior intra-oral structures with cervical metastases were all too frequently directed to the radiologist for "palliation." Similar lesions involving the bony pelvis or shoulder joint were declared hopeless.

But this pessimistic approach has steadily been changing. In 1935, Whipple and his associates[20] published the first report from their clinic on a radical attack upon the duodenum and head of pancreas for ampullar carcinoma, and more recently[21] they have summarized their experience and experiences of others with this technique for carcinoma of head of pancreas. Sweet[22,23] has demonstrated that the middle third of the esophagus and lower esophagus and proximal stomach can be resected with primary intrathoracic anastomosis with a reasonable mortality, resulting in excellent palliation. Sufficient time has not elapsed to judge the curability of this procedure. A combined abdominothoracic approach[24,25] for lesions of terminal esophagus, proximal or total stomach has much to recommend it. Radical surgery in advanced abdominal cancer with en bloc resections of involved contiguous structures is not only possible today, but has resulted in such significant palliation that one should reconsider his criteria of inoperability when faced with a bulky abdominal lesion with involvement of adjacent organs. Brunschwig[26a,26b] has summarized his experience with 100 cases of advanced cancer, previously declared inoperable. Certain it is, that there is an increasing tendency today to do primary gastro-intestinal resections in the face of hepatic and distant metastases to eliminate slow starvation, obstruction, pain and sepsis from the original lesion. Solitary pulmonary metastases from distant controlled primary lesions have been surgically attacked.[27,28] Bulky malignant tumors of the upper thigh, groin and buttocks with or without involvement of the adjacent hemi-pelvis may be removed by sacro-iliac disarticulation[29] converting a bedridden patient with a painful and often septic lesion into a partially ambulatory individual with a clean, painless wound.

Intra-oral neoplasms, especially with proven cervical metastases, are generally attended by a high morbidity by virtue of their encroachment on organs essential for mastication, deglutition, respiration and speech. Add to this the rich blood supply and high development of sensory nerves in the head and neck, and it becomes apparent that pain, anemia from intermittent blood loss, starvation, and respiratory obstruction are to be coped with frequently. Up until the past decade, this group of tumors fell within the exclusive domain of the radiologist, yielding a five year cure rate of 20 to 25 per cent for all intra-oral lesions exclusive of lip but also resulting in increased morbidity, due to radiation mucositis in the early treatment phase. In the later stages, radiation necrosis of soft tissues and/or adjacent bony and cartilaginous structures, exposure of great vessels, and sensory nerves would be noted, and in those who had the good fortune to survive treatment for ten to fifteen years the spectre of "radiation cancer" occasionally was to be contended with. Resection of necrotic facial bones, ligation of the carotid vessels, tracheotomy, nasal tube feedings judiciously used, singly or in combination, would ameliorate the situation in many instances. These considerations have prompted the development of radical procedures so designed as to resect the entire maxilla and orbit, or to combine hemisection of the mandible with superimposed lesion and ipsilateral radical neck dissection.[30] Obviously some lesions requiring such extensive surgery may recur locally or metastasize to distant structures with subsequent death—yet during this post operative period, these patients are more comfortable and if post operative radiation is used for local recurrence, one has but soft tissue to radiate in the vicinity of the wound.

NEUROSURGERY

Careful plotting of sensory pathways peripherally and within the spinal cord has granted the neurosurgeon a rational basis for blocking afferent nerves and tracts, often resulting in complete and perma-

nent relief of intractable pain. Cordotomy, rhizotomy, section of peripheral sensory nerves, and alcohol injection into subarachnoid space offer themselves for consideration, and the choice of any one procedure should be determined by (a) the location and rapidity of growth of the neoplasm, (b) probable life expectancy of patient, (c) amount and character of pain, (d) patient's condition as an operative risk, and (e) amount of opiates necessary to control pain. Grant[31] has summarized this problem, emphasizing that pain from neoplastic lesions can be relieved provided that the patient realizes it entails an operative procedure, associated with loss of sensation, possible motor weakness and occasionally sphincteric disturbance.

RADIATION THERAPY

The principles of radiation and radium therapy had their origin just before the turn of the past century and radiology has been an active science—constantly adding to and changing the modalities and techniques. In this short span of half a century we have jumped from the crude x-ray tube of Roentgen and pitchblende of the Curies to the present day cyclotron and uranium pile; if as much progress were made with the cause of cancer, there would be no need for this paper on the palliative treatment of neoplasia. The primary objective of radiation therapy is total eradication of neoplastic tissue. When this desideratum is not achieved owing to the inherent lack of radiosensitvity, then growth restraint, control of bleeding and infection, and relief of pain assume equal importance. The best palliation is achieved with the lymphoblastoma, epitheliomata of oro-pharynx, cervix and skin, embryoma of kidney, endothelial myeloma of bone and metastases from primary breast and testicular tumors. Primary tumors of gastro-intestinal tract, lung, esophagus, mediastinum, bone, thyroid, kidney and soft tissue sarcomas are relatively radioresistant. Small accessible lesions or residual disease following a course of external radiation may be implanted with radon seeds or needles, or may be suitable for an applicator containing radium or its emanation, radon. Supervoltage therapy has failed to demonstrate an appreciable advantage over the usual 200-250 k. v. apparatus.[32]

As a result of the fission process of uranium, radioactive isotopes are produced which can be purified chemically, calibrated for radioactivity, and used medically. The uranium pile is more efficient than the cyclotron, and larger quantities of radiactive isotopes are becoming available. Therapeutically, the energy emitted from this group of substances is equivalent to that of radium or its emanation gas, radon. The two substances most frequently employed to date have been radioactive phosphorus P 32 and radioactive iodine I 130, I 131.

Radioactive phosphorous, with a half life of 14.2 days releases Beta rays (high speed electrons) which produce intense ionization within a few millimeters of tissue, and chemically, in the body economy, it behaves as phosphorous. Inasmuch as pathological tissue in leukemias and lymphomata demonstrated a higher pickup of this agent, several series of patients with these diseases were treated with this isotope. Careful evaluation and comparison with the conventional x-ray treatment failed to record any increased advantage,[33] though there are fewer undesireable side effects. Polycythemia vera has been effectively controlled for long periods.

Radioactive iodine, a mixture of I 130, I 131 with half lives of 12.6 hours and 8.0 days, respectively, emits both Beta and the more penetrating Gamma ray, and is chemically identical with iodine. Physiologically, the thyroid shows the same affinity for the radioactive isotope as for the inert stable iodine. Several recent reports[34,35] indicate that well differentiated thyroid carcinomata will selectively pick up this agent and regression of metastases with marked symptomatic improvement may result, while the poorly differentiated and anaplastic thyroid lesions have not exhibited this tendency.

Other isotopes have been produced, notable radioactive iron, carbon, sodium, but these have, in the main, been used for biological studies.

GENERAL CONSIDERATIONS

In additon to the specific treatment described above, careful attention to many details in the patient's daily routine will contribute to his comfort. High caloric liquid diets supplemented with protein hydrolysates, hematinics and polyvitamin preparations are easily assimilable. Many chlorophyll deodorizers are available to cleanse the air of the patient's room. Ulcerating, foul smelling lesions, not amenable to surgical debridement or further radiation, will often respond to local applications of activated zinc peroxide, or ointment containing penicillin or furacin. Aluminum powder, synthetic resins or zine oxide will preserve skin from irritation due to draining intestinal fistulae. Small decubi-

tus ulcers can be prevented by frequent change of position and bedding, good skin hygiene and judicious use of rubber cushions. Excisions of the larger and more painful bedsores has been successfully effected by primary closure.[36]

The routine use of opiates and narcotics is to be deplored since many so called "terminal" patients live for many months, with resulting tolerance for medication and potential addiction. Attention to small details as described above may eliminate many foci of chronic discomfort, allowing reasonable comfort with salicylates, anodynes, antispasmodics and barbituates. When pain becomes a real issue, and is not amneable to nerve block, then opiates should be used as often as necessary for comfort of patient. There is a new agent for relief of pain, AN 148 (37), undergoing clinical trial which may well supplant our present narcotics since it has a low toxicity combined with no demonstrable tendency for habit formation. Cobra venom[38] has not been uniformly successful in relieving pain, but its use is justified if opiates fail. Thurz[39] has described the technique for use of intravenous alcohol, whereby euphoria and relaxed comfort may be assured for the depressed and suffering patient.

All too often, the physician attending a terminal cancer patient lends the impression that he is actually suffering more than the patient—this attitude results in feeling of hopelessness by the patient and attendants, and definitely lowers the morale of the family. It is recognized that individual problems will arise with different lesions. It is also recognized that the average physician will not have available the agents or the training necessary to carry out any of the described procedures. However, it would appear desirable to be familiar with some of the recent concepts in the treatment of terminal cancer. Utilization of any of the above techniques, singly or in combination, combined with personal and cheerful care will afford a longer and more comfortable life for the patient suffering from advanced cancer.

REFERENCES

1. Dorn, Harold: Public Health Report #3, 59, January 21, 1944.

2. Dublin, L. I.: American Journal Cancer, 29:736, 1937.

3. Journal National Cancer Institute, 6, p. 239-301, April, 1946.

4. Gilman, A. and Philips, F. S.: Science, 103:490, 1946.

5. Rhoads, C. P.: Journal American Medical Assn, 131:656, June 1946.

6. Goodman, L. S., Wintrobe, M. M., Damshek, W., Goodman, M. J., Gilman, A., and McLennan, M. T.: Journal American Medical Assn., 132:126, 1946.

7. Jacobson, L. O., Spurr, C. L., Barron, E. S. G., Smith, T., Lushbough, C. and Dick, G. F.: Journal American Medical Assn, 132:263, 1946.

8. Huggins, C. and Hodges, C. V.: Cancer Research 1:293-297, April 1941. ("Studies on Prostatic Cancer;" I, effect of castration of estrogen and of Androgen on serum Phosphases in Metastatic carcinoma of Prostate.)

9. Clarke, B. G. and Veits, H. R.: Journal American Medical Assn., 121:499-501, February 13, 1941. (Effect of Diethylstilbesterol on neurologic symptoms of carcinoma of prostate.)

10. Huggins, C.: Journal American Medical Assn., 131:576-581, June 15, 1946. (Prostatic cancer treated by orchiectomy; the 5 year results.)

11. Ulrich, P.: Unio. Internat. Contra Cancrum, 4:377, 1939. (Testosterone (hormone male) et son Rôle possible dans le treatment de Certanis Cancers du sein.)

12. Loeser, A.: Unio. Internat. Contra Cancrum, 4:375, 1939. (Male hormone in the treatment of cancer of the breast.)

13. Farrow, J. and Woodard, H.: Journal American Medical Assn., 118:339, 1942. (The influence of Androgenic and Estrongenic substances on the Serum Calcium.)

14. Adair, F. E., and Hermann, J. B.: Annals of Surgery, 123:1023-1035, June 1946. (The use of Testosterone Proprionate in the treatment of advanced carcinoma of the breast.)

15. Haddow et al. British Medical Journal, 2:393, 398, September 1944.

16. Nathanson, Ira, Cancer Research, 6:484, 1946. (Stilbesterol on advanced cancer of breast.)

17. Nathanson—unpublished data.

18. Adair, F. E., Treves, N., Farrow, J. H., Scharnagel, I. M.: Journal American Medical Assn., 128:161-167, May 1945. (Clinical effects of surgical and x-ray castration in mammary cancer.)

19. Treves, Abels, et al.: S. G. O. 76:589, 1944. (Orchiectomy on primary and metastatic carcinoma of male breast.)

20. Whipple, A. O., Parsons, W. B., Mullins, C. R.: Annals of Surgery, 102:763-779, 1935.

21. Whipple, A. O.: S. G. O., 82:623-631, 1946. (Observations on Radical Surgery for Lesions of the Pancreas.)

22. Sweet, R. H.: Annals of Surgery, 124:653-666, 1946. (Carcinoma of Midthoracic esophagus.)

23. Sweet, R. H.: New England Journal of Medicine, 233: 1-7, 1945.

24. Humphreys II, G. H.: Annals of Surgery, 124:288-299, 1946. (An approach to Resections of the Esophagus and Gastric Cardia.)

25. Garlock, J. H.: S. G. O., 83:737-741, December 1946. (Combined Abdominothoracic Approach for Carcinoma of Cardia and Lower Esophagus.)

26a. Brunschwig, A.: University of Chicago Press, 1947. (Radical Surgery in Advanced Abdominal Cencer)

26b. Brunschwig, A., Morton, D. R.: Annals of Surgery, 124: 746-754, 1946. (Resection of Abdominal Carcinoma

involving Liver and Spleen secondarily.)

27. Barney, J. J. O.: Journal of Urology, 52:406-407, November 1944.

28. Brezina, P. S. and Lindskog, G. E.: Journal Thoracic Surgery, 12:728-733, 1943.

29. Pack, G. T. and Ehrlich, H. F.: Annals of Surgery, 124:1-27, 1946. (Exarticulation of the Lower Extremities for Malignant Tumors.)

30. Sugarbaker, E. D.: S. G. O., 83:767-777, 1946. (Combined Jaw Resection, Neck Dissection for Metastatic Carcinoma of Cervical Nodes Secondarily Involving the Mandible.)

31. Grant, F. C.: Bulletin of N. Y. Academy of Medciine, 19:373-385, 1943.

32. Hocker, A. F., and Guttman, R. J.: American Journal of Roentgenology, 51:83, 1944. (3½ years' Experience with the 1000 Kilovolt Roentgen Therapy Unit at Memorial Hospital.)

33. Leucutia, T.: American Journal Roentgenology and Radium Therapy, 56:90-94, 1946.

34. Frantz, V. K., Ball, R. P., Keston, A. S. and Palmer, W. W.: Annals of Surgery, 119: 668-669, 1944. (Thyroid Carcinoma with Metastases; Studied with Radioactive Iodine.)

35. Seidlin, S. M., Marinelli, L. D., Oshry, E.: Journal American Medical Assn., 132:838-847, 1946. (Radioactive Iodine Therapy.)

36. White, J. C. and Hanun, W. G.: Annals of Surgery, 124: 1136-1147, 1946. (Primary Closure of Bedsores by Plastic Surgery.)

37. Scott, C. C. and Chen, Kik.: Journal Pharmacological and Experimental Therapy, 81:63, May 1946. (The Action of AN 148, a potent analgesic agent.)

38. Macht, D. I.: Annals of International Medicine II, 1924, 1938. (Therapeutic Experience with Cobra Venom.)

39. Thurz, D.: Wien Klin, Wchscher, 51: 691-692, 1932.

THE MEDICAL LIBRARY OF THE NEW BRITAIN GENERAL HOSPITAL

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The stimulus which a medical library imparts to the professional staff of a hospital is a prime factor in the development and maintenance of high medical standards. This principle is so well established that it requires no further elaboration. Yet a recent survey of existing libraries in non university hospitals has revealed that too frequently a few dusty obsolete texts and journals, usually contributed by members of the staff as discards from their personal libraries, and housed in inaccessible and poorly furnished quarters, constitute what is euphemistically called "The Medical Library." The library of the New Britain General Hospital has for years been no exception to this generalization. With the recent reorganization of our staff and the related desire to develop and implement a teaching program along lines approved by modern medical thought, the establishment of a medical library in fact as well as in name became of paramount and urgent importance. The manner by which this was accomplished, and the motivating philosophy behind this accomplishment are here presented in the hope that they may be of assistance to other institutions confronted with a similar problem.

Any discussion of hospital medical libraries should be prefaced by the cogent statement of the American College of Surgeons entitled "Minimum Standards for the Hospital Medical Library." The program as outlined in it was consistently followed in the organization of our library, and the statement is therefore reproduced in its entirety below:

"1. *Content.* All general hospitals shall maintain an adequate medical library comprised of a basic collection of carefully selected, authoritative medical textbooks and reference works of the latest edition, and files of current journals, including those which most effectively reflect recent developments in medicine, surgery, and those specialties which are represented in the clinical services of the hospital.

"2. *Housing.* The collection shall be housed in or adjacent to a convenient reading room furnished in such a manner as to encourage study and research. It shall be classified and arranged so that it is easily accessible to the librarian and members of the medical staff.

"3. *Personnel.* The library shall be under the supervision of a qualified librarian. She shall act as custodian of its contents and also shall arrange for the necessary cataloging and indexing which will

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enable the resident staff to do reference work quickly and easily. Assistance in the preparation of bibliographies, translations, abstracts, and reviews of the literature shall be made available either by employing a full time research librarian or by the use of the extension facilities offered by larger libraries.

"4. *Extension Facilities.* The librarian shall provide information and brochures describing the facilities that are offered to members of the medical profession by the staffs of specific libraries which have been established on a more extensive basis in order to supplement the work of the local librarian and to serve the literary needs of professional men regardless of their location.

"5. *Committee on the Library.* Selected members of the medical staff shall function as a permanent committee on the library, and their duties shall be to foster and develop the resources and interests of the library and to encourage the use of its facilities."

The need for a medical library had been frequently discussed by members of our staff, but during the war years no positive action toward its organization could be taken. In the fall of 1946, however, the staff Executive Committee believed the time was ripe to pursue the project energetically, and accordingly it appointed a Library Committee consisting of a surgeon, a physician, and a pathologist to explore the whole problem and to present recommendations for establishing a library in this hospital. Through consultations with deans of medical schools, by correspondence with the American Medical Association and the American College of Surgeons, and by personal visits to other already functioning hospital medical libraries, concrete suggestions were evolved. These were approved by the Executive Committee of the staff, and then presented to the Board of Directors.

LIBRARY FUND

The prime requirement for the establishment and maintenance of a library is, of course, the availability of necessary funds. It was felt that the hospital staff should accept financial responsibility, at least in part, for the library which would serve it. By motion unanimously adopted at a regular meeting of the staff, each member agreed to a tax of $15 per annum, this amount to be segregated for library purposes. The following tentative annual budget was then recommended to the Board of Directors of the hospital:

Journals	$1,000.00
Binding, etc.	1,000.00
Texts	500.00
Librarian and miscellaneous	2,500.00
Total	$5,000.00

The Board members were wholeheartedly in sympathy with the general idea of establishing a medical library, and agreed to provide the necessary funds which were to be obtained from three general sources:

1. Special annual staff assessment.
2. Library fees from students in the School of Nursing.
3. General hospital funds.

The hope was expressed that a library endowment fund could be obtained through the solicitation of one or more large contributions to be donated for this purpose.

LIBRARY QUARTERS

A survey of the hospital revealed that there was no available space which could be utilized for library purposes. Although future additions to the hospital plant were and are planned, the need for a library was immediate, and postponing its organization until future buildings were completed was deemed unwise. Accordingly the board decided to provide quarters for the library in a new laboratory extension then under construction. These quarters, which were completed on June 20, 1947, are admittedly inadequate, and it is hoped that a larger and more desirable area will be assigned to the library in the future additions to the hospital. For the present, however, the library consists of a large, well illuminated reading room attractively furnished with study tables, and an adjacent stack room with shelving for approximately 4,000 volumes.

LIBRARIAN

Provision in the recommended budget was made for the services of a full-time librarian, and soon after the budget was approved a qualified librarian was employed. Prior to the completion of the library quarters her work consisted of collecting and tabulating books and journals contributed by members of the staff, arranging for the binding of old volumes, organizing a system of cataloging and filing, and ordering journals and texts. Several months were required for these preliminary activities, but the time was utilized to good purpose because the library was functioning on the day

fter the quarters were officially declared available. Her present activities are not so much custodial as hey are cataloging, indexing, arranging for binding of journals, assisting in the preparation of bibliographies, and in general promoting the use of the ibrary.

COMBINED LIBRARY FOR STAFF AND NURSES

In order to be accredited, hospital Schools of Nursing must provide certain minimum library acilities. These are sometimes more extensive than he library facilities of the medical staff. Even in hose institutions where the medical staff library nd the nursing school library are of equal or nearly qual quality, the maintenance of two libraries is an nnecessary duplication of cost. Moreover, it tends o separate the staff needlessly and does not give proper consideration to members of the hospital ersonnel other than doctors and nurses. In this ospital the School of Nursing library consisted of large room with tables and stacks, books and ournals, which was located in the nurses' residence t some distance from the main hospital buildings. The library committee reviewed this dichotomy, nd recommended that the nurses' library and the taff library be amalgamated into a single unit deigned for physicians and nurses, and for other nembers of the professional staff including technicians, dietitians, record librarians, etc. In order o accomplish this, it was further suggested that a nember of the nursing staff be appointed to serve n the library committee. This recomendation was avorably received by the Board of Directors.

IBRARY COMMITTEE

Originally the Library Committee had been functioning as a sub-committee of the staff Executive Committee. When the Board of Directors had approved of the general project, it decided to organze the library administratively as a separate depart-ent of the hospital under the managing director nd to operate it professionally through recomendations of the Library Committee. This committee was then appointed directly by the Board of Directors, and included the original members of the Library Committee and, in addition, a member of he Nursing School staff, the principal of the School f Nursing.[1] The committee is now responsible irectly to the Board of Directors rather than to the staff Executive Committee. Its duties have been essentially those of organization of the library, selection of texts and journals, and the adoption of policies governing library practices. The librarian serves as secretary of the committee, and its deliberations are permanently recorded. Hereafter, the Library Committee will be appointed by the Board of Directors at its annual meeting.

LIBRARY CONTENT

The Library Committee was in unanimous agreement that in the selection of the library contents major emphasis should be placed on medical journals, bound and indexed, and that subsidiary interest should be given to modern texts representing the various fields of medical specialization. It was decided to review the library contents at periodic intervals and to replace out-of-date texts with new editions when these become available.

A major activity of the Library Committee was the selection of a representative list of journals. After numerous consultations with members of the professional staff, and within the limits of our budget, the following list of journals was finally approved for purchase. The list is classified according to the general headings of the "Current List of Medical Literature":

Allergy
- Journal of Allergy

Anatomy: Histology
- Stain Technology

Anesthesia
- Anesthesiology
- Current Researches in Anesthesia and Analgesia

Bacteriology: Parasitology
- Bacteriological Reviews
- Journal of Bacteriology
- Parasitology

Biology: Embryology
- Federation Proceedings
- Journal of Experimental Biology
- Biological Abstracts

Cancerology: Oncology
- Cancer Research
- Journal of the National Cancer Institute
- Cancer

Cardiovascular System
- American Heart Journal

Chemistry: Physics
- Biochemical Journal
- Chemical Abstracts
- Chemical Reviews
- Journal of Biological Chemistry

Dentistry: Stomatology
- American Journal of Orthodontics and Oral Surgery
- Journal of the American Dental Association

[1] The Committee consists of the following members: Dr. Harold M. Clarke, Miss Vivian Duxbury, Dr. Paul D. Rosahn, Dr. Vincent J. Squillacote.

Journal of Dental Research
Journal of Oral Surgery
Dermatology
Archives of Dermatology and Syphilology
Journal of Investigative Dermatology
Dietetics: Foods: Nutrition
Nutrition Reviews
Digestive System
American Journal of Digestive Diseases
Gastroenterology
Review of Gastroenterology
Endocrinology
Endocrinology
Journal of Clinical Endocrinology
Transactions of the American Association for the Study of Goiter
Gynecology: Obstetrics
American Journal of Obstetrics and Gynecology
Journal of Obstetrics and Gynaecology of the British Empire
Obstetrical and Gynecological Survey
Quarterly Review of Obstetrics and Gynecology
Surgery, Gynecology and Obstetrics
Hematology
Blood
Hospitals
Modern Hospital
Immunology: Serology
Journal of Immunology
Industrial Hygiene: Sociology
Occupational Medicine
Infectious Diseases: Epidemiology
Journal of Infectious Diseases
Medicine
Acta Medica Scandinavica
American Journal of Medical Sciences
American Journal of Medicine
American Review of Soviet Medicine
Annals of Biochemistry and Experimental Medicine
Annals of Internal Medicine
Archives of Internal Medicine
Archives of Physical Medicine
British Medical Journal
Bulletin of the Johns Hopkins Hospital
Bulletin of the New England Medical Center
Bulletin of the New York Academy of Medicine
Bulletin of the United States Army Medical Department
Connecticut State Medical Journal
Geriatrics
Journal of the American Medical Association
Journal of Clinical Investigation
Journal of Experimental Medicine
Journal of Laboratory and Clinical Medicine
Lancet
Medical Clinics of North America
Medicine
New England Journal of Medicine
Proceedings of the Society for Experimental Biology and Medicine
Proceedings of the Staff Meetings of the Mayo Clinic
Psychosomatic Medicine
Quarterly Journal of Medicine
Sigma Xi Quarterly
United States Naval Medical Bulletin
Yale Journal of Biology and Medicine
Miscellaneous
American Scientist
Current List of Medical Literature
Hygeia
Quarterly Cumulative Index Medicus
Review of Scientific Instruments
Science
Neurology: Psychiatry
Archives of Neurology and Psychiatry
Brain
Journal of Neurology, Neurosurgery and Psychiatry
Nursing
American Journal of Nursing
Industrial Nursing
Public Health Nursing
Trained Nurse and Hospital Reveiw
Ophthalmology
American Journal of Ophthalmology
Archives of Ophthalmology
Otorhinolaryngology: Phoniatry
Annals of Otology, Rhinology and Laryngology
Archives of Otolaryngology
Laryngoscope
Quarterly Review of Otorhinolaryngology and Broncho-Esophagology
Pathology
Aota Pathologica Microbiologica Scandinavica
American Journal of Clinical Pathology
American Journal of Pathology
Archives of Pathology
Journal of Pathology and Bacteriology
Pediatrics: Child Welfare
American Journal of Diseases of Children
Journal of Pediatrics
Pharmacology: Pharmacy
Journal of Pharmacology and Experimental Therapeutics
Physiology
American Journal of Physiology
Physiological Reviews
Public Health: Sanitation
American Journal of Public Health
Radiology: Phototherapy
American Journal of Roentgenology and Radium Therapy
British Journal of Radiology
Nucleonics
Radiography
Radiology
Surgery: Traumatology
American Journal of Surgery
Annals of Surgery
Archives of Surgery
British Journal of Surgery
Journal of Bone and Joint Surgery
Journal of the International College of Surgeons
Journal of Thoracic Surgery

Surgery
Surgery, Gynecology and Obstetrics with International Abstract of Surgery
Surgical Clinics of North America
Tropical Medicine
American Journal of Tropical Medicine
Tuberculosis
American Review of Tuberculosis
Urology
British Journal of Urology
Journal of Urology
Venereal Diseases: Sexology
American Journal of Syphilis, Gonorrhea and Venereal Diseases
Journal of Venereal Disease Information

The next problem was the selection of representative texts, and here again it was necessary to work within the limits of our budget. Many modern reference works were contributed by members of the staff, and others of various descriptions were transferred from the library of the School of Nursing. These represented a well integrated nucleus, but in addition approximately 75 standard modern works not already on hand were approved for purchase. It should be remembered that the primary aim of the Library Committee was to concentrate on journals rather than on texts. Each year outdated volumes will be removed and replaced by modern editions, and new books and texts will be added. This way the library will at all times house current thinking in the field of medicine.

Contributions of texts and journals from members of the staff were particularly desired. To accomplish this end, a form letter was mailed to each staff physician asking for contributions of reference volumes and back issues of journals. The response from the staff was gratifying beyond all expectation. Many modern texts and approximately 200 volumes of back journals were contributed. In some instances complete files to date of certain journals were donated. These were organized, missing issues secured where possible from the publisher and other sources, and complete volumes were sent to the bindery.

MEDICAL LIBRARY POLICIES

In a survey of other libraries it became evident that there are two basic conflicting attitudes in library policy. With rigid custodial care and restrictions on the withdrawal of texts and journals for leisure time reading outside of the library, a minimum of losses is assured. On the other hand, where comparative freedom exists in the use of the library and where custodial care is only incidental the library content receives wide circulation and usage but losses are maximum. In considering this problem the Library Committee was of the opinion that it was more desirable to have wide circulation with its accompanying probable losses than to have no losses and limited circulation.

A second problem concerned the library of the School of Nursing which had been in existence for many years. This was well equipped with reference works, nursing text books and a few journals, and it played an important part in nursing education. In order to amalgamate the medical library with the library of the School of Nursing it was decided to utilize the latter as a library annex for study purposes only, and to stock it with reference works which were not to be issued on loan. All other volumes were removed from the School of Nursing library and housed in the main library where they were cataloged, indexed and made available for loan. After these decisions had been reached, the following library policies were adopted and are now in use:

1. The Medical Library consists of a Main Library and Library Annex. The Main Library is located in the basement of the main hospital building and consists of a reading room and stack room. General reference books, medical journals and books, and bound or unbound periodicals to be issued on a loan basis will be housed in the Main Library. The Library Annex is located in the nurses' residence and will comprise reference volumes and other material which may not be borrowed. It will not contain any books or journals to be issued on a loan basis. All loan material as indicated above will be located in the Main Library.

2. The Main Library is intended for use by all professional personnel connected with the hospital. This includes physicians, nurses, dietitians, physiotherapists, technicians, social service workers, etc.

3. The Library Annex is for the convenience of the nursing staff. It will be unsupervised and open at all times.

4. The Main Library will be open and the Librarian will be on duty Monday through Friday from 8:30 A. M. to 5:00 P. M., and Saturday from 8:30 A. M. to 12:00 noon. It will be closed on Sunday and on all legal holidays officially observed by the hospital. During hours when the Main Library is open it can be used both as a reading room and for the issuance of loan material.

5. During hours when the library is closed it may be used as a reading room only. In such instances the key may be obtained from the Admitting Office if signed for and returned promptly after the user leaves the library.

6. All books and periodicals taken from the Main Library must be charged with the Librarian. At times when the Librarian is off duty no material may be removed.

7. With the exceptions noted below, books and bound periodicals may be borrowed for two weeks, but may be

renewed for another two weeks provided the books have not been requested by another reader. If, during the period of renewal, they are requested by another reader, they are subject to recall at once. If a volume which is on loan is needed for a reserved shelf, it may be recalled before the limit of the loan period. The latest bound volume of a journal may be borrowed for one week only.

8. Reference books, such as systems of medicine and surgery, bibliographies, indices, abstract journals, encyclopedias, and books reserved on the "New Book Table," may not be taken from the library under any circumstances.

9. Unbound periodicals, books reserved for special courses, and reference books (except those restricted under paragraph 8) may be borrowed for overnight only, i.e., after 4:00 P. M. Monday through Friday and 11:00 A. M. Saturday. They must be returned to the library by 10:00 A. M. the following morning. Such material taken out Saturday must be returned by 10:00 A. M. Monday. Books may be returned at the information desk only when the library is closed.

10. If a book or journal is lost the borrower will be taxed the cost of replacement.

Enthusiastic expressions of approval from members of the professional staff greeted the formal opening of the library. The library policies are intended to be flexible and will be changed as experience demands. The hope is to develop a living library of modern thought which will play an important part in the constant search for increased knowledge. In this way medical care will be improved and the patient will ultimately be the beneficiary.

DOCTORS AND NURSES OF OTHER LANDS

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IN THESE war years many an American doctor had an Odyssey of his own, of which he had never dreamed in the staid days back home. I would like to submit a representative sample. I never reached the Hesperides, these fabled islands away to the west and south, as the Yale Unit and others appeared to regard New Zealand, but I was sent to many distant places, and met doctors and nurses of different countries. This account will tell something of them. I hope it reflects the kindly hospitality with which we Americans were everywhere received.

One of the medical officers on the transport that took us to Naples was the son of the President of Brazil. The young doctor was an orthopedic surgeon in their Air Force, and a good one.

The road to the Pasteur Institute in Algiers was, strictly speaking, out of bounds the afternoon I walked there. Plague was reported in the city, and I passed a dead rat in the gutter. The doctors at the Institute were cordial to a visitor in uniform who brought a letter from another laboratory worker in Washington. They showed me their work, especially in BCG, and in spite of my feeble French I got a good deal out of it. Someone will some day relate the civilian uses of the oil drums, big and little, which the war scattered so widely around the world. In Algiers some of the drums were rabbit cages.

El Shaat lay just beyond the Suez Canal, where one Sunday morning I counted the masts and bridges of 45 Liberties moving through the sand out to the Red Sea, to India with supplies for Mountbatten or for China over the Hump. The camp at El Shaat held 23,000 Yugoslav refugees, all Partisans. They had slipped over from Dalmatia to Italy, and were brought from there to Egypt. The Chief Medical Officer was a young Scotch captain, who had been in Ethiopia. In his hospital and infirmaries he had Yugoslav, Czech, Palestinian, Greek, and American physicians, men and women. British and American nurses taught practical nursing to eager Yugoslav girls. The three dentists were Yugoslavs; there was even a refugee woman who had made dentures back home.

On the plaster walls of the pediatric ward an artist in the camp had sketched Donald Duck, in a bold free way that won children and visitors. The x-ray work for the hospital was done over at Suez, by a Czech major in an English general hospital. Medical supplies were scrounged from the RAMC. The Yugoslavs sang in the trucks coming back from

work. What a concert they had the night word came that Split was free! Tito would not let them take any money for their work, laborers or doctors.

In the nearby Greek camp, at Moses' Wells (the very place, so tradition has it, where Moses struck the rock and water gushed out) Greek doctors and nurses had a hospital in the buildings of the Egyptian quarantine station standing beside the Red Sea to receive the pilgrims coming back from Mecca. They were training nursing aides, too. Next day they were to give diphtheria toxoid to several hundred children in the refugee camp. For this they had four needles, and a nurse rode back with us to El Shaat to negotiate the loan of 2 cc. syringe for the morrow. But first they served tea to the visiting doctor and gave him some sea-shells to take home.

Up in Palestine the refugee camp at Nuseirat, near Gaza, held 10,000 Greeks, mostly from the Aegean Islands. The Chief Medical Officer here was a tall Englishman from Cyprus. Most of his doctors were Greek, and his nurses English, American or Greek. Nursing aides were being trained here also. Nuseirat had been an Allied Army camp earlier. On one wall of the mess hall at the hospital someone in an English hospital unit had drawn some fine sketches from Pickwick. Later a Polish unit came, and they had an artist too, for on another wall were scenes from Polish folk tales, equally well drawn. Australians were at Nuseirat at one time, but their hospital unit evidently had no artist.

Mention of the Poles reminds me of the major in the medical corps who came to Charlottesville when I was in the School of Military Government. He spoke English well, but his accent was puzzling. He had been a gynecologist in Warsaw before the war, escaped to Rumania after Poland fell, rejoined the army in France until that fell. Then he had two years and a half in Scotland. When I learned that, a light dawned. He even wore his bonnet like a McGregor. How he talked after three months in Virginia is anyone's guess.

Just over the border from Palestine, in the province of Sinai back in Egypt, was a small camp of Yugoslav royalists. The children looked neat, intelligent and better nourished than the Partisan youngsters. I wonder whether they will ever see their homes again. The camp doctor at El Arish, a Czech, served us little cups of Turkish coffee before we started to drive back to Gaza. The desert is surprisingly attractive, especially in the pastel shades of dawn and dusk.

At Nuseirat Cairo had telephoned that Washington was ordering me back, to go out to a new office in Australia. I had 24 hours in Jerusalem, for which I shall always be grateful. The RAF brought me back to Cairo, and the ATC dropped me in New York. The steel floor of a C-47 is cold at night over the Sahara, but one learns to sleep. I had Christmas at home, and the children ate some Palestinian oranges, and had little silver Crusader crosses to wear.

A jungle knife in a dresser drawer is a relic of the briefing they gave us on the West Coast. The time is commonplace now, but I am still awed by the thought of 52 hours elapsed time from San Francisco to Brisbane. After dimouts along the Atlantic, the jeweled pattern of street lights in the Bay cities was like fairy land. When I woke again the moonlight above the clouds seemed in a different world. At Christmas Island half the garrison lined up to watch the plane come in, and we had fresh cow's milk at our evening lunch. I wonder who is watching the palm trees on Christmas Island now.

Australia is strange and it is familiar, and most of us liked it very much. I am particularly grateful to those who made it possible for some Australian doctors to visit the States in years past, for they gave me a welcome that was warming, and assistance that was valuable. The Commonwealth Department of Health, the medical schools, the medical corps of the Army, Navy and Air Force were cooperative and helpful. They were interested in UNRRA and were alert to help.

The medical schools in Australia are on a six year basis, with premedical and medical schools joined together. There is a medical school in five of the six states, with none in Tasmania. I heard no discussion of a second school in either Sydney or Melbourne, each larger than Boston or New Orleans. The intern and resident pattern is much like ours. Full-time clinical teaching is coming in slowly.

Australia exercised a much stricter manpower control over her population than we did, and that included medical people. State committees decided who went into Service and who stayed home and where, and their decisions were reviewed by a Commonwealth committee. In general the profession was left to make its own decisions, but sometimes the Cabinet stepped in. The state committees regulated civilian practice pretty strictly. Doctors could be, and were, assigned to communities and made to stay there. A young doctor finishing his internship

might draw one of the Services, or he might be sent to practice in "the out-back." If sent, he went. The system insured medical care for a population going all out on the war effort, though it seems a bit foreign to our thinking.

The refugee doctors from Europe did not receive full Australian licenses. A few were able to repeat one, two or three years in a local medical school, graduate and were licensed. In view of the shortage of doctors the others were examined orally and given emergency licenses good "for the duration." The plan was discussed of giving permanent licenses to those who did well, but in August 1945 no steps had been taken to carry this out.

Australian nurses are excellent people. Their profession is in transition right now. For entrance their schools require some two years of high school; few girls have had any college work. Salaries are low, though this is helped by strict price controls. Physiotherapists in Australia have higher requirements for their schools than do nurses, and higher incomes after graduation. But the leaders of nursing are strong people, and their nurses are fine nurses. I sent eleven of them to Europe to help in the displaced person camps, and I am proud of the work they did there. Three of them were lieutenant colonels in the Army or Air Force; one, Matron Doherty, took over the nursing in Belsen Camp.

There was a great deal of interest in Australia in Greece, the little country that sided with Britain when the sky was dark. Australians and New Zealanders fought in Greece, and after the fall many were hidden by the Greeks, and at last escaped. One trim nursing sister with an Eighth Army ribbon came to ask to go to Greece in relief work. "I've been there," she said. "They met us at the dock, and played us in. They came down when we left and played us out, and I'd like to go back to help them."

New Zealand sent six good nurses for the refugee camps in Europe, and was ready to send more, but mistakenly I saved them for work in the Far East that never materialized. The six were sturdy, capable nurses, most of them graduates also of the school of public health nursing in Wellington, which New Zealand had set up on the model of Toronto. A tall Yugoslav doctor left a very prosperous practice (in New Zealand, one gathered, all the practitioners were flourishing, and the fishing, when they got any time for it, was good) to go back to Europe to do his bit. His wife had begged him not to set foot in Yugoslavia again, for he was not a Partisan.

In Melbourne I saw the hospital building where the Lakeside Unit from Cleveland fought such a bitter war in the early days. When the Western Reserve people came, they took over the new seven story brick building of the Melbourne General Hospital, just being finished. There they spent almost two years, a mile from the center of a city of a million people, with a fine climate, excellent food, good stores, friendly hosts. In their letters home some of them doubtless managed to hint of hardships. Just how, is hard to see, but such is the way of soldiers. When they followed the war north to New Guinea they may have been glad of the medical opportunity, but they must have noticed the change in their surroundings. Up in Sydney, on the other hand, the Hopkins Unit were in frame pavilions ten miles out of the city; the Royal Navy took over their plant early in 1945.

Twice in that year I was in New Guinea and nearby parts, seeing what the Dutch were doing medically in civilian relief. It was good, and in quantity it was sufficient for New Guinea, but after studying Dutch personnel and medical supplies one got a bit worried over what might happen in the crowded islands farther west, still to be freed. Some of their supplies they were getting from MacArthur —civil priorities are rather down on the list—and they were also storing captured Japanese drugs. The chief Civil Affairs officer in Dutch New Guinea was a Javanese Moslem, as was the second ranking medical officer. Dutch officers worked very well with and under them. This was educational to an American. The Dutch had male nurses, known as "Mantris," whom they used widely in their smaller centers. One, with a skillful pair of hands, I watched holding a yaws clinic in a one room mission school in a village by the shore, where the dwellings stood up on stilts over the water. One wonders what Hollandia and Biak, Noemfor and Morotai are like now; Biak, where I saw three general hospitals with seven thousand bed capacity on one mile of shore.

As Holland was freed from the Germans, the Dutch recruited doctors and nurses and sent them by air or sea to Australia, to be ready to help in the Netherlands East Indies. One young doctor came to my apartment to call. It was May, wintertime in Sydney, and when he took off his army overcoat at my urging I gasped, to myself. I had heard they had starved in Holland the winter before, in the

months between Antwerp and the Rhine; but here I could see. He said he had eaten well on the voyage out, too.

You can read about the destruction in Manila, and look at pictures and talk with people who have been there, but it is not until you ride down Taft Avenue and see the Philippine General Hospital, the Bureau of Science and the medical school of the University of the Philippines that it really sinks in on you. The Philippine General was one of the great hospitals of the world. Today it cares for 500 patients—it once had 900—the outpatient building is in use, with the roof off one wing, and they have started up the school of nursing, though the Americans still use the nurses' home for a hotel. Most of the buildings can be used, though they will take a world of repairing. They are typical of the attitudes one takes by turns in Manila, of depression because of the tremendous damage and of courage because much solid structure remains on which to rebuild. At the medical school the anatomy department had students dissecting at two tables, in that world of ruin. The dean had his faculty teaching by the bedside, and they were going on. The medical school of Santo Tomas University, until July 1 the oldest university under the American flag, lost its teaching hospital when San Juan de Dios, in Intramuros, was wiped out; but the canny fathers bought the equipment of a departed army hospital.

The serum laboratory at Alabang, outside Manila, was fortunately untouched, and even had a large stock of prewar agar and peptone left. The existence of this stock some Japanese had held as proof of American and Filipino plans for bacteriological warfare. Now it is a godsend to a post war budget, for the laboratory has been turning out vaccines since March 1945. Some of you may have sent bundles to the used clothing drive. You will be glad to hear of the doctor at Alabang who told me of the bales that had come that morning to the laboratory. His wife had had no new cloth for the family for years, and they were very grateful for these things. You and I did not think they might go to professional people, did we?

Down at Iloilo I was the guest of Major Buck of West Hartford, commanding the Station Hospital, housed in the buildings of the Baptist Mission Hospital. The roof of the nurses' home was gone; the Japanese did that. St. Paul de Chatres, in Iloilo, was untouched and busy, for it was run by the French sisters, and the Japanese had not been at war with the French. Near Tacloban I heard of a young Filipino doctor who had just resigned his post with the Department of Health, because his salary of Pesos 100 would not pay his rent. Yet before the war, a friend told me, a young doctor could save enough on that salary in two years to equip his office when he went into private practice.

Up in Manila, where even senior officers were housed three in a room, one of my roommates was Lieutenant Colonel Paul N. Harper of Bridgeport, then assistant director of preventive medicine in the Pacific Theater. One Sunday he took me down to New Bilibid Prison for a glimpse of the 4,000 Japanese POW's in the hospital there. Some of the women and children, just brought in from the hills, were living skeletons. Japanese doctors and nurses were taking care of their own people under American supervision. Over in the operating room one of our men said they found the Japanese surgeons had skillful fingers, but "their aseptic technique was different."

In the northern suburbs some of the patients in the National Psychopathic Hospital had run away during the disturbances. One quadrangle was taken over by an emergency orthopedic hospital, caring for gunshot and fracture cases from the days of liberation and from traffic accidents since. The chief surgeon was a Filipino doctor with excellent training in the States, and he had developed and inspired a good staff. He had gotten hold of the equipment and supplies in an emergency hospital of the army, and with that and some extra cots he was caring for some 200 patients. He used the popular closed method for the compound fractures, and his results looked good.

At Singapore, Colonel W. J. Vickers, director of health, took me to a meeting of the Welfare Council and introduced me to Dr. Mary Tan, a Chinese woman trained at Edinburgh, in charge of maternal and child health work for the municipality. She told me of ten health centers; the one I saw was a fine concrete and tile building where hundreds of children were getting Australian milk daily. Dr. Tan had stayed in charge under Japanese rule. She said to me: "They put a Japanese doctor at the head, who was interested in our work and tried to get larger appropriations, so after a while they took him away. I felt the British were coming back, and I wanted to be here when they came. So I just did my work, didn't listen to the radio or talk politics." A Chinese clerk at the Raffles Hotel told me how he

felt when he first heard an American bomber flying over: "We weren't deserted, and we were going to be free some day." The registrar of vital statistics was an Anglo-Indian. Singapore is indeed the crossroads of the East.

Dr. Min Sein in Rangoon wore the uniform of a colonel in the Indian Army, but he was looking forward to the time when he could again be professor of internal medicine in the medical school. He complained that the 14th Army had taken over the medical school building, and equipment was lost. I ventured that armies always did things like that, certainly in Manila or Singapore. I hope he succeeds in his plans for his school. All through Southeast Asia schools are needing help, and I hope they get it. One of the medical education problems in Burma was solved when Allied bombing wiped out the Class B medical school in Rangoon. If it had to be one of the two schools, it is well it was the poorer.

My contacts were largely with the medical corps of the Indian Army, but I was frankly impressed with the teamwork of the British and Indian officers, whether in Burma, Java or Siam.

Over at Bangkok the medical school had lost part of the pathology building and Siriraj Hospital, one of its pediatric wards, after which they moved to the suburbs. By February 1946 they were back again, and it was a busy, crowded place through which old friends showed me. The school was reorganized in the 20's with the help of the Rockfeller Foundation and of the father of the present king of Siam. The father, H.R.H. Prince Mahidol of Songkla, was an AOA at Harvard a generation ago. My friends showed me equipment worn out, and told me of supplies long since used up, but at that I thought it in the best condition of any medical school east of Calcutta. They had kept up their standards well. Three of those in charge of nursing were trained at Boston's Children's Hospital.

At Chulalongkorn Hospital, a 350 bed institution run by the Red Cross Society of Siam, Phya Damrong Baedyakum, trained in London, was still in charge. It was the leading hospital of the country, but rewashed bandages were drying on the lawn, so I realized how short of supplies they had been, and still were. My guide was a nurse whom I had helped send to Manila for training. "All our hospital beds are filled with Siamese," she said, "and here are the tents of an Indian General Hospital on the lawn between our buildings. They have half the operating pavilion, and the Dutch internee patients have the nurses' classroom building. So between our Allies and ourselves, we are pretty full." She learned her understatements in school at Bedford College, London.

The RAF generously flew me in a five passenger plane up to my old hospital among the mountains at Chiengnai, and the British Army sent along a gift of drugs. During the war McCormick was a Siamese military hospital, and its 125 beds grew to take 1,800 patients. It is in good condition, and back in the hands of my old chief. Our nurses were there, and the training school was flourishing. They told me of the night when American bombers hit the railway station and the godowns around. "We got 300 patients that night, the electric lights failed, and we operated all night long. I never used to go to the air raid shelters in the yard," the chief nurse said, "but after that I did."

In Bangkok I saw again a group of doctors who have been trained in public health at Hopkins or Harvard. They now have responsible positions and are doing excellent work. There was a similar but smaller group in Burma.

From Bangkok I went by jeep to where the Burma Railway crosses the Me Klong. There the Japanese had built a monument, a substantial one, with inscriptions in eight languages, in memory of the workmen, some 75,000 in number, who gave their lives in the building of that railroad. You think of the doctors, Australian, British, Indian, Dutch, and one or two American, who strove with little but their own ingenuity to keep up the health of their forces, off there in the jungle. Driving back, I met a Dutch army doctor who had been through it and was hoping sometime to get back to Europe.

The Polyclinic in Saigon, in French Indo-China, takes care of 1,500-2,000 outpatients of a morning, French, Annamite and Chinese doctors seeing Chinese and Annamite patients. They were still very short of drugs, and were treating beriberi with strychnine only, being without vitamines. Soap had long been short, so there was much scabies, but there was also little or no sulphur or vaseline. The Pasteur Institute, however, was doing a fine job of manufacturing vaccines, including dried smallpox vaccine, which holds its potency without an icebox in the tropics.

With a final appointment in UNRRA as chief medical officer for displaced persons in the Far East, I took two shiploads of Chinese refugees back to China to Amoy and Shanghai. Then, while waiting

orders, I saw something of UNRRA work in China, and its difficulties and its achievements. The chief medical officer was a Yugoslav who had been in China before with the League of Nations. Helping him were doctors, nurses, and engineers from the U. S., the U. K., Australia, India, El Salvador, the Philippines, Czechoslovakia, New Zealand, working well together.

The whole Chinese picture is darkened and distorted by the deplorable political situation. I would rather think of the refugees, whom you get to know and like, of the plain people at Hangchow who smiled and gave the victory sign when a truck load of Americans drove by, of the earnestness of the doctors in the Communist areas as reported by our field people, of the nurses from the Chinese Red Cross Hospital who sang carols in the halls of the American General Hospital on Christmas morning of 1945.

The Japanese were going home from Shanghai, military and civilians, 50,000 a week, in Liberties, LST's, Japanese freighters, little Japanese destroyers and gunboats, six square feet of floor space for each person and his baggage. Watching them was educational. The soldiers were efficient in their own way, and toward us neither surly nor obsequious. Army nurses carried their own baggage. There was one group who stood on the dock in a driving rain for an hour one March night, until someone sent them below on another vessel. On a hospital ship nurses carried stretchers. Mattresses were laid on the deck, which, of course, is what they are used to. The Japanese had their own systems of immunizations and of examinations. They were very methodical, but in general I was not impressed with their medical work. Those boarding ships of Japanese Navy had their feet and legs sprayed with creolin mixture, for what purpose I never learned.

The Japanese civilians won our hearty respect. They may be used to regimentation or they may be well disciplined, but these groups were organized and well behaved. They stood waiting for hours, then moved when a leader or sub-leader told them to. There was no yelling. They very seldom crowded or pushed. They helped each other, they smiled on occasion. Their children did not cry, and kept their manners. People like this are going to rise again.

Planes were hard to get when it was time for me to start home, so I worked my way back as surgeon on a destroyer escort, via Pearl and Panama. A D-E, by the way, is considerably smaller than a destroyer, and is by no means to be compared with the Queen Mary for stability. My roommate, the signal officer, was from Greenwich and showed me something of the marvels of radar. I was slung over to another D-E by breeches buoy one day, to help its doctor with an appendix. He was, I suspect, slightly more unsteady on his feet than I was, and we put the patient ashore at Midway where he did very well. Later I diagnosed an appendix early on my own ship. We called in the others, and did the operation on the wardroom table. Three sailors on my ship wanted to enter medical school this fall; I hope they were all admitted. Our exec was headed for Yale Law School.

I was very fortunate in my assignments. They led me to a variety of interesting places, though as does happen the value of what was accomplished was sometimes restricted by decisions at headquarters. One thing the months taught me, without the shadow of a doubt. It is possible, even easy and certainly pleasant, to work with doctors and nurses from other countries. French, Egyptian, English, Scotch, Irish, Yusoslav, Czech, Greek, Palestinian, American, Australian, New Zealand, Chinese, Dutch, Malay, Filipino, Siamese, Burmese, Indian, South American, Japanese—the important thing is the individual's training, ability and personality. His tint does not matter, though as for speech you do have to find some way of communicating ideas. But we can work together, and that discovery, which many of us have made, is important for the years ahead.

The summer of 1946 was sometimes criticized in Connecticut. Sometimes a native would say it was too dry. Later it might be too wet. I found its weather glorious and thought it a beautiful state. For I was home again.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

The Surgical Insurance Program

At the semi-annual meeting of the House of Delegates action was deferred for the time being on the recommendation for a surgical and obstetrical insurance program. While any plan adopted by the Society will not be completely fool proof at its inception the best of plans will be unworkable unless the medical profession of our state has a full understanding of it and takes active participation in its operation. Such participation means signing an agreement with the Society to accept the charges for services in the fee table as the complete fee for persons in the set income limit. It means further that the physician agrees to abide by the rulings of the Society's Committee on Prepaid Medical Insurance in any administrative problems which may arise. It is understood by the participating physician that insured persons whose incomes exceed the set income limit shall have indemnity toward the total bill charged but the total bill for such persons should be consistent with the usual fee prevailing in the community for the service rendered. It should also be remembered that participation in the plan in no way restricts the right of any physician to refuse to treat any patient for appropriate reasons.

The basic principle of the Plan is simple and the details are also readily comprehensible. The suggested fee table which is obviously of particular interest has been given most careful study by the Committee who have sought wide consultation in its establishment. In recommending the adoption of the Plan the Council has expressed confidence that it is suitable and will be serviceable to the members of our Society.

The House of Delegates in deferring action did so in order that further consideration should be given not only by the members of that body but by all of our members through special meetings which will be held by the County Associations.

In this important consideration let us remember that the insurance companies who will aid us in making this program successful have long enjoyed the confidence of the public and that industrial leaders and organized labor groups have recognized the importance of insurance plans for workers in industry. Furthermore, most of the other states of the Union are now operating similar plans and it is recognized by our national medical leaders that their development and operation is the strongest bulwark that we can have against central federal control of medical practice.

As members of the Connecticut State Medical Society we now have the opportunity of rejecting or adopting an insurance plan which we are informed is based on sound business principles. In its serious consideration let us not be unmindful that we are able to do this under a democratic system of government which still remains a heritage without price.

Prescription Blanks

The Connecticut State Medical Society and the Connecticut Pharmaceutical Association have maintained a Joint Conference Committee since 1941. The original committee was headed by Stanley B. Weld. Inactive during the war years, it has resumed its functions during the last two years under the chairmanship of Dr. William T. Salter. Its purpose is to better the relationships between both professions by providing a sounding board for the mutual problems of both groups.

The first step taken by the 1941 group as well as the 1945 Committee was to request that physicians refrain from using prescription blanks bearing a name of a pharmacist or pharmacy, and pharmacists were asked to cease printing these blanks in this manner. It was felt that this practice was bound to be misunderstood and had no justification whatsoever. During the last two years the Joint Conference Committee has intensified its educational program along these lines, and it is pleased to announce that the majority of pharmacists and physicians have cooperated wholeheartedly with this request.

The resolution describing the thoughts of the Committee as it concerned prescription blanks was made in the form of a request for voluntary cooperation, but unfortunately a number of members of both groups have continued this practice. Therefore, at the request of the Joint Conference Committee, the State Pharmacy Commission has issued the following regulation:

"Regulation No. 38—No pharmacist or pharmacy shall provide a physician, dentist, or veterinarian with prescription blanks bearing a pharmacist's or pharmacy's name thereon."

The Commission took this action because the impetus of this practice originates with the pharmacist. Most pharmacists have cooperated cheerfully. It is reported, however, that a few pharmacists, having been informed that this regulation was about to be issued, rushed to the printer with orders for thousands of prescription blanks bearing their store name and the name of a physician. This was done to beat the deadline set by the regulation. In so doing they could not be accused of violating the law even though by their action they were nullifying its effect for some time to come.

This attempt to circumvent the regulation can not succeed without the cooperation of the physician. It is suggested that all physicians remove the name of any store or merchant from all prescription blanks wherever possible, and, if this is not possible, to refrain from using the blanks at all. Physicians do not stoop to advertise their own services. Why should they indulge in amateur merchandising?

The Hospital Library

The development of the medical library as an active force in the medical activities of the modern hospital is a recognized necessity. One of the ever present problems of hospital administration is the proper management of the medical library and it is obvious that a good deal of such responsibility belongs in the hands of the medical staff. Dr. Rosahn and Mrs. Olmsted in the present issue describe the organization of the medical library in one of our Connecticut hospitals. Their experience gives valuable information, not the least of which is the special attention to the important field of periodical literature.

Fortunately in our state we possess two large and efficient medical libraries, the Hartford Medical Library and the Medical Library at Yale. A forward looking program should be developed which would utilize these centers to greater advantage for the hospital medical libraries for the whole state. This has been discussed in one of our State Society committees and we shall look for further progress in this direction.

Are You Rowing or Riding?

The interim report of the Board of Trustees of the Building Fund which appears elsewhere in this issue is a cause for sincere reflection. The total amount, approximately $75,000 pledged to date, is a fine showing on the part of those who have contributed. However, the fact that nearly one half of our members have contributed nothing is not pleasant reading. One wonders why this is so. Are there members who feel that unless a relatively large amount is subscribed that a more modest contribution will not be welcome? Obviously this is false reasoning. We refuse to believe that nearly half of our members have no interest in providing adequate facilities for our present overcrowded central office. We prefer to think that the greater part of this attitude is the result of procrastination. However, the time has arrived when the Board is thinking in terms of brick and mortar. If you are one of the 48 per cent why not reach for your fountain pen right now, and make your weight felt in the boat.

The Purpose of State Medical Societies

Dr. Barker in his address given before The Colorado State Medical Society speaks with the authority of extended experience on the purpose of state medical societies. His remarks should be interesting to many members of our society who have never considered very seriously this important question. As Dr. Barker pointed out, the physician, because of his somewhat unique privileges in society, has definite public responsibilities beyond the cure of sick people. It is through the state medical society that the application of such responsibilities often will find its most useful channel. His emphasis upon the necessity for a more positive attitude on the part of American Medicine is a progressive type of thinking that is definitely needed today if we would remove from Medicine what has been construed as an attitude of defense. Dr. Barker's remarks were directed primarily to a Colorado audience but they will be equally appreciated here for he is a prophet also in his own land.

The Solution To the Nursing Crisis

The organized nursing profession is aroused to the present acute crisis in nursing services for patients. It is calling upon the medical profession to assist in interesting more qualified young women to enroll in nursing schools and upon the laity to solve the threefold problem of inadequate economic security, poor legislation and faulty distribution. Physicians, through their prestige in the community and their individual contacts with patients, have an unequalled opportunity to select and encourage young women of the right caliber to select nursing as a life work. The opportunities in our training schools for better social and recreational opportunities as well as for financial assistance are known to every physician. According to the figures released by The American Nurses Association the total freshman enrollment in 1,295 schools in 1945 was 56,567. In 1946 this dropped to 30,899 and in 1947 indications are for an even greater drop. The same Association estimates that 41,000 additional registered nurses are needed to meet today's requirements and that by 1950 more than 160,000 additional nurses will be required to meet our needs.

It is not surprising when unskilled labor is receiving $1.50 per hour and skilled labor from $2.50 up to find the nurse dissatisfied with her financial lot. One year ago the average cash salaries for nurses in all fields amounted to $170 to $175 per month, and out of this the majority provided their own living quarters. One of every four receives less than $14[illegible] per month. A large number still work as many as 54 or more hours a week and the vast majority of nurses work at least 48 hours a week. They ask for adequate economic security and satisfactory conditions of employment.

Every state has passed legislation providing standards for the registration of nurses but unfortunately these standards vary from state to state and in many instances are not very high. This situation removes the incentive for better preparation in states where the requirements are low. Only 26 states, Hawaii and Porto Rico have laws that provide for licensure of practical nurses and/or attendants. Only New York and Hawaii have laws that require licensure of all nurses. In many states the laws are not compulsory, thus permitting anyone, even without any preparation, to practice nursing without a license. Organized nursing asks for adequate legal control of nursing by the states.

Of particular interest should be the non profit nationwide counseling and placement service which organized nursing has made available without charge to nurses and employers alike. This has been set up to offset the tendency of nurses to concentrate in metropolitan areas and to promote a more equitable distribution of nurses, placing the right nurse in the right job.

A very popular solution to the present nursing crisis advanced by some is the training of more practical nurses to take over the major part of bedside nursing in hospitals. The president of the American Nurses Association has characterized this as "detrimental and dangerous" to the patient's health. Such practical nurses may be used in increasing numbers if they are properly trained, licensed under state laws which will weed out the incompetents, and properly placed and supervised. It is the contention of the spokesman for organized nursing that the present crisis will be overcome only when the profession is made sufficiently desirable to attract and retain a sufficient number of qualified women on a basis of its professional status and economic stability. We hasten to add that, as with the young man or woman entering medical school there must be a willingness to serve her fellowman for, after all, if the spirit is not there no amount of financial compensation or pleasant surroundings will produce a real nurse.

THE PRESIDENT'S PAGE

We need no public relations council to tell us that actions speak louder than words. The public will judge us on what we do, not on what we say.

Inability or unwillingness to understand the other man's point of view causes most of the world's oversupply of ill feeling. So when we devise a program for prepaid medical care, we should keep in mind what the public desires as well as what it needs, although in our democracy these two are not necessarily the same especially before elections.

Quite unconsciously and with the most generous motives physicians have insulated themselves from awareness of the public's point of view by reason of "professional courtesy." If physicians were accustomed to pay for medical services in the same measure as their patients do, I venture to say that the public's point of view would be more accurately understood and the golden rule would work its magic. This is well understood by many physicians and this admonition is intended for the few who sometimes forget.

As you consider the prepaid medical program, I suggest that you hum over to yourselves the poem of Robert Burns,

"O wad some power the giftie gie us
To see oursels as others see us!
It wad frae monie a blunder free us,
An' foolish notion."

J. R. Miller

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REPORT OF THE SECRETARY

To the House of Delegates December 4, 1946

The Secretary will present no report at this time except statistics of membership and that is a gratifying record indeed. At the beginning of 1947, the Society had 2,237 members, its largest recorded enrolment up to that time. During 1947, 227 new members have been elected and there have been lost by death 28 and by resignation and transfer 51, a total of 79, leaving a net gain of 148 for the year. As of today the membership of the Society is 2,385.

It was just about ten years ago that the Society took the first steps toward strengthening its organization and usefulness and the creation of a full-time administration. During those ten years, the membership in the Society has increased by almost one thousand members.

MEMBERSHIP

FAIRFIELD COUNTY

Membership–January 1, 1947	515	
New Members	69	584
Less:		
Deaths	5	
Lost by resignation, transfer, non-payment of dues, etc.	10	15
Membership–December 4, 1947		569

HARTFORD COUNTY

Membership–January 1, 1947	664	
New Members	53	717
Less:		
Deaths	9	
Lost by resignation, transfer, non-payment of dues, etc.	9	18
Membership–December 4, 1947		699

LITCHFIELD COUNTY

Membership–January 1, 1947	94	
New Members	11	105
Less:		
Deaths	3	
Lost by resignation, transfer, non-payment of dues, etc.	2	5
Membership–December 4, 1947		100

MIDDLESEX COUNTY

Membership–January 1, 1947	80	
New Members	6	
Less:		
Deaths	0	
Lost by resignation, transfer, non-payment of dues, etc.	1	
Membership–December 4, 1947		

NEW HAVEN COUNTY

Membership–January 1, 1947	680	
New Members	63	7
Less:		
Deaths	8	
Lost by resignation, transfer, non-payment of dues, etc.	19	
Membership–December 4, 1947		7

NEW LONDON COUNTY

Membership–January 1, 1947	131	
New Members	19	1
Less:		
Deaths	2	
Lost by resignation, transfer, non-payment of dues, etc.	9	
Membership–December 4, 1947		1

)LLAND COUNTY		
Membership–January 1, 1947	19	
New Members	1	20
Less:		
Deaths	0	
Lost by resignation, transfer, non-payment of dues, etc.	1	1
Membership–December 4, 1947		19
'INDHAM COUNTY		
Membership–January 1, 1947	46	
New Members	4	50
Less:		
Deaths	1	
Lost by resignation, transfer, non-payment of dues, etc.	0	1
Membership–December 4, 1947		49
SSOCIATE MEMBERS		
January 1, 1947	8	
New Member	1	
Associate Members–December 4, 1947		9
'otal Society Membership–January 1, 1947		2237
New Members		227
Total Membership–December 4, 1947		2464
Less:		
Deaths	28	
Resignations, transfer, etc.	51	
	79	79
Total Society Membership–December 4, 1947		2385
Net Gain for year 148		

NTERIM REPORT OF BOARD OF TRUSTEES OF BUILDING FUND

The Board of Trustees of the Building Fund wishes to port that substantial progress is being made in accumulat- g the Society's Building Fund. To date 1093 members of e Society have contributed $68,470. This is 45.8 per cent the membership and represents average individual con- ibutions of $62.64. The total amount pledged to the Fund, cluding memorial gifts, is $74,635. After paying for the ilding site, there remains $55,721.04 in cash on deposit to e credit of the Fund including earned interest.

Twenty elected members of this House of Delegates have)t contributed to the Building Fund and they were re- inded of it by inclusion of the pledge card with the an-)uncement of this meeting. Conditions in the building dustry have not improved much during the past year and is still not certain when building operations can be undertaken wisely and not extravagantly, but it is hoped that the spring of 1948 may change the circumstances enough so that actual construction of the building can be contemplated.

It is quite clear that we do not yet have money enough to complete this project and additional efforts will be put forward by the Board of Trustees to stimulate contribution from the half of the membership which have not given and local committees will be encouraged to aid in personal solicitation. Substantial additions to the Fund are expected from memorial gifts. Already one thousand dollars has been given as a memorial to Dr. Amos Givens of Stamford. Generous friends of Dr. Edward Bradstreet of Meriden have contributed more than two thousand dollars and the Board of Managers of the Institute of Living, Hartford, has contributed two thousand dollars as a memorial to Dr. Eli Todd, a distinguished member of this Society and the first superintendent of the Institute. Other memorial funds are now in the process of collection and still more are planned.

This building project has been delayed longer than was anticipated, but that delay arose in ways quite outside the control of the Board of Trustees. The war intervened and as an aftermath of the war we were confronted with the highest building costs of all time, but the Board looks forward optimistically and knows that finally the Society will have its building and all of the pride and service that will go with it.

Meetings Held During December

Thursday, December 4, 3:30 P. M.
Semi-annual meeting of the House of Delegates of the Society, New Haven Medical Association

7:00 P. M.
Midyear dinner of the Society and the Woman's Auxiliary, New Haven Lawn Club

Monday, December 8, 10:30 A. M.
Advisory Committee on Public Law 725, State Capitol

4:40 P. M.
Liaison committee with the Institute of Occupational Medicine and Hygiene

Wednesday, December 10, 6:00 P. M.
Committee on Medical Care of Veterans, Graduates Club

Thursday, December 11, 4:00 P. M.
Program Committee, New Haven Hospital

Wednesday, December 17, 6:00 P. M.
Committee on Industrial Health, 178 Jackman Avenue, Bridgeport

Friday, December 19, 3:30 P. M.
Council of the Society

THE PURPOSE OF STATE MEDICAL SOCIETIES

CREIGHTON BARKER, M.D., *New Haven*

The Author. *Executive Secretary, Connecticut State Medical Society*

THERE is a small, and I may say, somewhat unusual little band of men and a few women whose primary concern is the executive management of the state medical societies of America. Most of these people are not physicians and it is my exciting and exacting privilege to be one of a scant handful of them engaged in this field. By mention of this I do not wish to imply that a medically educated administrator is better or worse than one without that training, but I do wish to emphasize how few there are.

It is probable that in the inner circles of their own societies these executives are articulate, but generally speaking they have little to say about the broad policies of the mass of medical societies, yet I venture the guess that this group more than any other knows the operation, the weaknesses and the strength of medical societies. I have not discussed these matters formally with many, but through the years I have absorbed a lot of ideas from others and learned lots of things.

Perhaps I should examine and justify our claim to knowledge though to me it is quite clear. We secretaries work, day in and day out, close to our jobs, big and little, and provide continuity for rather complex operations. We serve under society administrations which change from year to year, and sometimes presidents are good and smart, other times they leave much to be desired, at best they are here today and gone tomorrow. Directing boards are not invariably alert and, elected as they usually are on a geographical basis, it is not always easy to find a properly qualified trustee or councilor from a given area. Often members of these boards are so distracted by private concerns that their service is weak. Committees occasionally are stupid. Motives can be selfish and coordination lacking. These are some of the bad things, but there are many good things too and we must see it all and add it up and try to make it work. This is the experience from which our knowledge stems.

So then, here I am, having come nearly across th continent to be a commentator on state medie societies, not Colorado, not Connecticut, but sta societies as I see them, what they are at, and wh and how they are doing it. Yesterday, as your gue I attended a House of Delegates meeting in m twelfth state.

I have asked myself, "What is a state medie society?", is it a scientific and educational organiz tion as we would have the Bureau of Intern Revenue believe? Is it a protective guild of skille craftsmen? Is it a polite device for spreading prop ganda? Is it a special minority for influencing legi lation? Is it a social club through which one ma extend his acquaintance and prestige? Is it an inst tution for public service? Of course no sing answer is enough. Medical societies try to be, an are, combinations of them all. Some emphasiz certain things more than others with varyin degrees of success, but this is what they try to b It is complicated, isn't it, when you stop to thin of it? And it is further complicated when is acknowledged that a society — any society — people. It is people that confuse it most and th people who make up a medical society are som thing special, all educated, mostly intelligen quaintly conceited, strict individualists usually wit a common interest and peculiarly unselfish. Mi them all up and add a few honest and some bogu idealists and a spatter of the unscrupulous and yo have a medical society, an organization the like which is hard to find.

If you really want to know all you can abou medical societies it is important to understan something of their history. Not exactly their chro ological history or the biographies of the peop who have led them and made them, but rather th evolution of their philosophies. Time does not pe mit a detailed review and only the chief epochs wi be sketched in but it is a fascinating progress t explore and it is striking how closely social an economic environment influenced it.

Education was almost the sole purpose of th earliest medical societies. Medical schools were fe

Presented at a meeting of the Colorado State Medical Society, Denver, Colorado, September 18, 1947

in America in the eighteenth century, books were scarce and the medical organizations set out to provide a means for the spread of knowledge and for intellectual communion. As knowledge increased education became even more important and the societies undertook to strengthen and formalize it by founding medical schools. This marked the second step in the first or cultural phase of medical societies' purposes. As the economic and public position of the trained physicians became secure and enviable, it was assailed on every hand by quacks and pretenders and to protect their members the societies became exclusive guilds requiring examination before election and adopting rules of behavior. These rules usually provided expulsion from membership for consorting and consulting with non members and for the use of secret remedies. This period produced the most stringent restriction on members that the societies have imposed and also marked the beginning of interest in public legislation when the societies sought legal requirements for licensure to practice.

This early progress I have outlined took place east of the Alleghenies, except for the notable achievements in the Western Reserve and the vigor displayed in the valley of the Ohio and western Kentucky. Eastern medical culture was transplanted there at an early date and included the founding of the first medical school west of the mountains at Lexington and the splendid romance of its library dragged by ox-cart through the Cumberland Gap.

After the start in the East none of these medical organization movements can be timed exactly by dates because of geographical expansion but the next purposeful phase was the extension of interest on the part of societies in outside affairs and their fruitful efforts to establish hospitals both public and charitable for the care of the sick and the insane. This concern with public welfare continued and later manifested itself in urging legislation in the public health field and the creation of state departments of health.

Meanwhile medical practice was forsaking empiricism and its strange ideas of therapeutics and accepting the scientific facts research had produced and the societies again engaged in self-education and the extension of clinical teaching. As a result of this vastly broadened knowledge, specialization in medicine developed rapidly, societies with special interests were established and for a time at least the educational purposes of the state organizations no longer seemed to be of first importance.

I have given these few paragraphs to historical review because I believe we should realize that medical societies for more than a century and a half have suffered from growing pains and uncertainties. They have always been affected by shifting social forces as they are now and have been dismayed often.

So we come to today and let us examine where we are now and in which direction we are going. We are living in a time marked by a summation of world changes more far-reaching than any in previous history. These changes have included all aspects of human relationships and they have arisen largely from transformations that have occurred in economic life and the world relations involved in the production and distribution of commodities. There is no phase of human behavior that has remained unaffected and medicine cannot expect exemption, but as a result the medical societies find themselves somewhat confused. Will they become protective, political, propagandizing organizations, or cling with dignity to their traditional cultural purposes? I do not pretend to know the answers, but I have some opinions.

Above all else, I believe that although they are given unusual privileges by law and custom, physicians are engaged in public service and the responsibilities we have go beyond the kindliness and skill we bestow as individuals on sick people. These extra responsibilities in public service should find their application through state medical societies and those societies will serve best if they aim actually to aid government in its increasing interest in the health and welfare of our people. This can be done by seeking opportunities to serve in advisory capacities and seeing to it that able members are appointed to boards and commissions in those fields where informed medical judgment is of the highest importance. There is also a direct advantage in this policy for it protects medicine from unwise planning that might be unfortunate to us.

This interest in public affairs will lead inevitably to political implications which must be handled with skill and honesty. I see no reason why a state medical society as such should not be concerned with public politics providing that concern is without prejudice or partisanship. Indeed, the present position of organized medicine before the people would be stronger had we in the past evidenced more constructive interest in public affairs. I think

you will agree that the legislative programs of most state societies, and perhaps of the American Medical Association, although I do not propose to deal with it, have been defensive. They have been fighting against something instead of proposing and furthering the passage of legislation that will be in the public good. Last winter I watched with considerable care medical legislation that was proposed during the legislative sessions in almost all of the states, and the reaction of medical societies to these proposals. It was rare indeed to find measures introduced and supported by medical societies which were not primarily advantageous to medicine and only rarely was I aware of instances of constructive legislation being introduced and supported by state societies. There are exceptions to this of course, and notable among them is your own splendid success in modernizing public health administration for Colorado, but largely our legislative interest is negative. This negativism runs through all of our response to the proposals for a socialistic pattern of medical care for America. The conflict between medicine and advocates of this socialism is not a contest between two groups concerning the allotment of the supply of medical care. It is a dispute concerning what system of social organization best serves the human welfare. We do not reject their collectivism because we begrudge the benefits that would allegedly derive from the scheme and I hope we do not oppose it solely because we think it would be economically unfortunate for medicine. But that is the general reaction on the part of the public, because we have not been positive enough that this socialistic plan would reduce the masses to the status of serfs in regard to medical care entirely at the mercy of irresponsible bureaucrats. It is a matter still unsolved, still urgent, and a persistent challenge to our statesmanship.

Education is the next purpose of a medical society that I will discuss and there are two kinds of education. First, the traditional objective of medical societies to keep members informed of progress in medical science which on the whole I think is fairly well carried out, one way or another, if not by the state societies and their journals, then by local and special units whose chief purpose is often the dissemination of knowledge. The other educational objective is a new concept and it is the education of the public. The people are entitled to knowledge of public health, methods for maintaining health, good sense in seeking medical assistance and the honest economics of medical care. Bringing all this to the public is a project of vast proportions and it is not easy for medical societies to do it without specially trained personnel but it is to my mind one of the most important avenues of public service in which medical societies can engage. Your willingness to accept this responsibility is vastly to your credit.

This audience would sense an omission if I had nothing to say about public relations even though you have before you at this meeting the long and painstaking report on public relations for your Society prepared by Raymond Rich. I have read Mr. Rich's report and am impressed by parts of it, but discussion of it by me would be inappropriate.

Serious consideration of the public relations of medical societies is relatively new and most of us should confess a good deal of ignorance of the whole business.

I have heard it talked about with zeal and enthusiasm, but I must admit I have not always understood what was being said. I am not confusing publicity with public relations. I am sure medical societies are entitled to a certain amount of sensible publicity so that the public may know what we are doing, particularly our participation in public affairs. A medical society deserves and should get a good press! Public relations, however, seems to be something else and I assume means the maintenance of good public opinion. I am for that, and it starts, I think, with the individual physician being an honest, good citizen, always doing the best he can for his patients. From him it extends upward to the state society which in itself should be an honest, good citizen, always doing the best it can for its patients, that is the public. Whether the prestige of medicine is improved by going much further than that with circus methods, I do not know. I am sure there are times when elaborate public relations programs accomplish more in satisfaction to the planner than in actual enhancement of the position of medicine, and any society, regardless of its budget, should be quite sure that its plans have good hopes of success and are not just fireworks. Public relations is an exciting Wonderland for adventure and there is no lack of slick White Rabbits willing to show us around.

A quiet and effective means of producing favorable public opinion for state medical societies is the extension of their participation in voluntary organizations engaged in the health and welfare field

as Dr. Murphey proposed yesterday in his report. With alert planning and consistent effort our societies can place useful members on the boards of directors of these private agencies and accomplish three desirable ends. First, the agencies are materially helped by capable medical guidance; next, the ideals and policies of medicine can be introduced into the operation of such agencies which when left to themselves occasionally have peculiar ideas. And finally, the medical society, through its representatives, is brought into continuous contact with citizens who are likely to be important civic and social leaders. I have seen this plan work so well that coupled with constructive aid to state government I believe it to be the most substantial way for developing good public opinion and confidence.

Society executives are concerned frequently by the lack of interest in society affairs on the part of many members. I do not refer to attendance at meetings, but rather to participating in the important work that must be done if we are to fulfill our purpose. An official of the American Medical Association with long experience in its administration has told me that of the more than 125,000 members of the state societies making up the American Association, only about 3,000 are engaged in the multitude of activities which the state societies and the American Medical Association are carrying on. It may be the remaining 122,000 think it is sufficient if they criticize what the 3,000 do, but I do not think it is. Perhaps some of the fault lies with us and our leaders in that we do not search widely enough for people who will be interested and do a good job but we are content to use the same ones over and over again, particularly if they are friends whose abilities are known. Employed administrative officers find it impolitic to discourage the appointment of some members whom they know to be inadequate when presidents and council members suggest such appointments on the basis of friendship or professional expediency. Another handicap is the persistent effort to seek representation from geographical areas in the state with only little regard to the qualifications required for certain tasks. Medical society leaders have great responsibility in stimulating membership participation and broadening interest, and this responsibility may not always be realized fully. I think it is especially important that younger members be given opportunities to bring fresh thinking to some of our recurrent problems and contribute new ideas to meet new circumstances. Ideas and plans that were good a dozen years ago do not always suffice now.

Until rather recently most of the state societies were meagerly financed but during the past ten years or so dues have been increased so that perhaps half of the state societies have budgets which are reasonably adequate. Of course the societies in the few states with large membership have ample income with relatively low individual dues, and in one of these states where the dues did appear to be inordinately high, the annual fee has just been reduced. It is in the states where membership is under 3,000 that the financial problem presents and the smaller the society the more difficult it becomes. Gradually and led largely by Colorado and other western states, the importance of ample financial support for the state medical organization is being realized and the states where token dues of five or six dollars were assessed have changed their policy. This is a period of broadened usefulness for medical societies which was overdue and everyone knows it costs money, but coming from a part of the country where frugality is indigenous I think sometimes society budgets are fantastic and extravagant, especially in the hazy field of public relations I have mentioned before. I like to see money spent wisely and I know it can be in medical society operation. Probably the future will hold bigger budgets rather than smaller, for that is the way we do things in America.

There will always be a group in every society who object to the dues, no matter what they may be. These are the people who ask the question, "What do I get out of the state medical society?" They are also the people who make the loudest commotion if anything goes wrong in the legislature or in other ways to affect their personal affairs. They rarely do anything but criticize and there is not much you can do about them, fortunately I believe their number is dwindling.

A majority of the state societies publish their own journals and in a few areas a group of societies combine, as you do here. Also, a number of the larger county organizations maintain journals. These publications vary widely in character and appearance. Some are definitely of the house organ type, others are fine scientific periodicals. It is not easy to gauge what influence these journals have but that they are potential instruments of great good cannot be questioned. It is estimated that they carry nearly two million dollars of advertising a year.

I see all of these state journals from time to time and am impressed by their differences. It it not always the great and prosperous society that produces the best journal. Some of those coming from the smaller states seem to me to be superior. I do not think anyone will take exception to a statement that the *New England Medical Journal*, published by the Massachusetts State Medical Society, is probably the outstanding state journal. It is the oldest, has been published weekly for well over a hundred years and all of that time has been one of the great American medical journals. The death last week of its editor, Robert Nye, is a tragic loss. His journal enjoyed the unusual distinction of having an outside paid circulation which is more than three times as large as its distribution among members of the Massachusetts Medical Society. From this journal at the top they vary all the way down to some which are pretty bad. But there has been, I think, a general improvement in many of them during the last few years. At least their format has improved and they look better. But I see one or two from great and wealthy societies which still have room for betterment.

It is interesting to speculate whether the contents of these journals reflect what the readers want or what the editors provide. Probably it is a combination of both, and it would be dangerous to set a pattern for state journals all across the country. Some areas want erudite publications, others prefer their journal to be an outlet for the publication of clinical observations by the members themselves, and some places apparently prefer intimate news and gossip.

It would be repetitious to go into fine detail in a discussion of all of the purposes of state medical journals because to do so would be to quote largely from an intelligent review of the subject recently published by John Farrell of the Rhode Island Medical Society. Although I do not agree with all of his comments, he has presented a fine analysis and I commend it to you. I do wish, however, to touch upon editorial policy and I cannot do better than to quote directly from Mr. Farrell's opinion and he says:

"The editorial is the heart of the journal, but it does not beat very loudly in most states, and it takes its place as the number one malady of our publications.

"Our editorials must assume a role of interpreting what has happened in the realm of medicine and public health, both locally and nationally, of e plaining the relations of one thing to another, a their functions. Our editorials must reflect t opinions and decisions of the medical profession our states and they must speak not alone to t membership of our Societies, but to the gener public. We must follow the precept of Josep Pulitzer and talk to a nation, not to a select cor mittee.

"A good editorial department will make a journ live. It will exert force upon the opinions of t people in matters of vital importance regardi their health. The editorial must not reflect t viewpoint of the editor; it must represent objectiv ly the thinking of the Society as seen through t eyes of a well informed editorial staff. We shou allot no space for narrow-minded opinions, n should we be prejudiced unduly against all wh disagree with our opinions.

"But when we know that we are being attacke or when we see anywhere the threat to the profe sion or to the medical care of the people, we cann be militant enough. Too often do the state journa become verbose in editorials without pointi definitely and with finality to what is wrong, wh it is wrong, and why the medical profession cha lenges the evil as it sees it."

It is Mr. Farrell's belief and mine also, that o journals too often hesitate to enter public co troversy, because the attending publicity is co sidered unfavorable, even though the cause is ju

It is realized that many of our journals are edit by people who are underpaid if they are paid all, under experienced and crowded for time, b I am sure many of the journals should seek ne vitality in their editorial departments.

It was not my intent in this address to quo specific experiences in my own small state becau I realize that it offers only a limited sample. Ho ever, in connection with the journal question, v have recently collected some information which think will be enlightening. Early this year o Society appointed a committee with the long tit "The Committee to Study the Organization a Objectives of the Connecticut State Medic Society," it is commonly known as the "Committ of Sixteen." I asked the House of Delegates for t appointment of this committee at its semi-annu meeting in December of last year because I believ it was time that our Society had information co cerning what the customers thought. I may live

regret having made this suggestion to the Society but in any case I am going to find out what they think. No administrative officer is a member of the committee. One of this committee's projects is an appraisal of reader interest in our journal, and I think you will be interested in some generalizations which have appeared. The inquiry took the form of a questionnaire distributed to all of our members and first of all we were gratified by the response. Already more than a third of our active membership has returned their answers, which is an extraordinary result on a questionnaire with us. Only three have suggested that the journal be discontinued and in one instance at least it was not understood that the journal was more than self-supporting and that no part of the dues go to its financing. We have tried to balance our journal contents by publishing the best clinical material available, a good deal of discussion of social and economic questions presented from all aspects, and the usual news from the county associations. So far there has been one outstanding comment, somewhat to my disappointment, it is that our readers are far more interested in the publication of articles on clinical medicine than in the discussion of social, political and economic problems. Perhaps we are not as alert to social change in our old and somewhat conservative pattern of life as other areas may be, but I feel quite sure if we follow the results of this survey we should give much additional emphasis to purely medical subjects rather than to medical economics, even though we would like our members to know more about the world they live in. In our study we have been agreeably surprised by the large proportion of our readers who record their interest in the advertising pages.

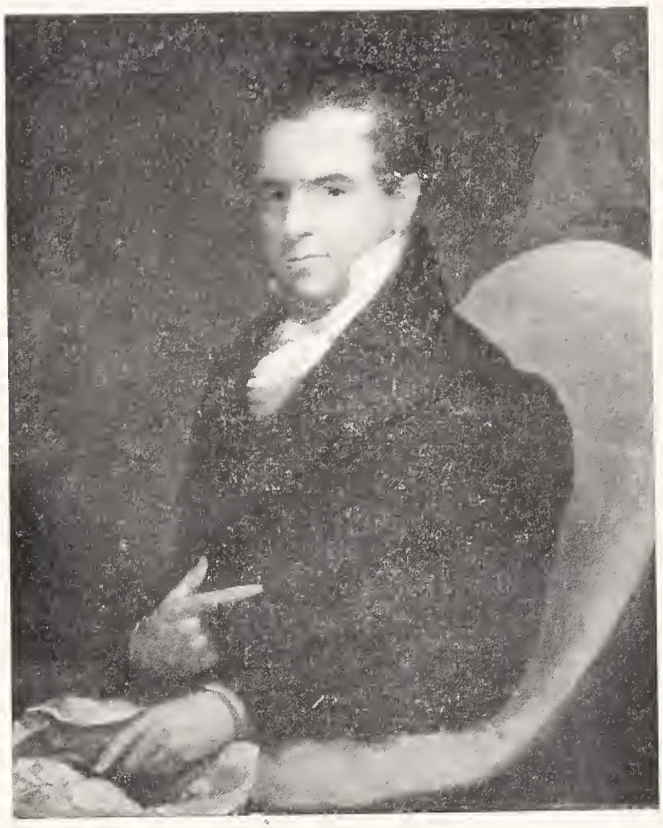
I suppose other states have made similar appraisals of their journals and I think it would be of great help to us who are concerned with these publications to have a survey made of state journals in general the country over. We have a problem of public relations within ourselves, that is the relation of society administration, including journals, to the medical public, which is our membership, and we should be successful with that before we try to extend our influence to the public at large.

I might go on for a long time more with the good and bad of state medical societies. Many of the things I would say would be known to you already. Others would be the result of close and occasionally cynical personal observation, but in the end it would all add up much the same. Medical societies have always been a valuable part of our civilization, they have tended to be selfish and self-seeking, while in my opinion their greatest usefulness to society and the profession of medicine will come from generous and understanding public service. To operate these societies and to relate them to their environment requires inevitably an amount of inside and outside politics. These politics should be carried on with honor and a single objective, that of improving the society in its service to the people and to its members. It is almost too much to expect that all members of a society will take a vital interest in its affairs and its progress, but every effort should be used to increase the interest of individuals and give them opportunities to contribute to an enterprise which is their own.

Finally, like every other human achievement, success comes from wise and skillful leadership. The choice of those leaders for your society lies with you, your judgment is reflected in whom you choose to lead you and to manage your affairs. You can decide what kind of a society you want, constructive criticism is healthy, prejudiced criticism is worthless. The successful operation of a medical society like everything else is based on wisdom and work. You are taking many wise and forward moving steps in Colorado, you have smart people here. It must be gratifying to Harvey Sethman to work with you and you are fortunate in having him work for you, he is a skillful person and has the high respect of all of us engaged in medical society operation.

At the last I want to say that the profession of medicine is not just a company of odd little men each intent on making as much money as he can. There is something in medicine that is bigger than any one of us and that fine bigness can find its expression best through our medical societies.

Fifth Memorial Gift to Building Fund



ELI TODD, M.D.

The Board of Directors of the Institute of Living, the third oldest institution in America devoted to the treatment of nervous and mental disease, has contributed $2,000 to the Society's building fund.

The gift has been made as a memorial to Dr. Eli Todd, the hospital's first superintendent, and to commemorate the founding of the Institute by the State Medical Society in 1822. This is the fifth memorial gift to be received by the Trustees of the Building Fund.

Dr. Todd, the son of a New Haven merchant, was born on July 22, 1769. He achieved a brilliant record at Yale University, traveled widely, and upon his return to New Haven chose a career in medicine. He apprenticed himself to Dr. Ebenezer Beardsley of that city, who was then engaged "in the practice of the physick" and a leader in the group which founded the New Haven County Medical Association.

After his apprenticeship, Dr. Todd removed to Farmington and later to Hartford. During his association with Ebenezer Beardsley he developed an interest in organized medicine, which resulted in his founding of the Society of Medical Friends while he was a resident of Farmington. The Society of Medical Friends was a forerunner of the State Medical Society.

Dr. Todd's interest in medical organization continued throughout his life, and it was this interest which motivated his efforts to establish a hospital for the care of "insane" persons. During this period there was superstition concerning mental disease and public indifference to its treatment. Todd was the leader in bringing the subject to open public discussion, and he aroused sympathy for the thousand unfortunates in our state who were neglected.

In 1820, in an address before the Hartford County Medical Association, he expressed his conviction that "mental disorder is as definitely a manifestation of disease as is fever or a fracture," and bluntly declared: "It is our duty as civilized men to attack this disease."

At the State Medical Convention in 1821 he urged that a hospital be established for the treatment of the increasing number of insane persons in Connecticut. So persuasive were his arguments that convention named a commission to investigate insanity in the state. Following this study, the commission reported such conclusive findings that the State Medical Society voted every cent in its treasury to aid in the founding of such a hospital.

Spurred by this action, a campaign for funds was launched, and Dr. Todd labored to assure its success. Contributors were informed that the new institution would be named "The Retreat," that it would not be a custodial asylum, but a hospital for the treatment of those cases considered curable. The campaign was well received, and 1,700 persons contributed $19,000. Their contributions ranged from twelve and one half cents, a coin of the period, to $300, and included "a gross of New London Bilious Pills, market price $30." The City of Hartford contributed $4,000, on condition that the hospital be located in that city.

The General Assembly, in its 1822 session, granted a petition for incorporation of the new institution and appropriated $5,000 for its use. Five months later the subscribers met to organize and to choose the first directors and officers of the Hartford Retreat. Dr. Todd was unanimously elected superintendent and a Board of Medical Visitors was named. This Board has been continued and now comprises former presidents of the State Medical Society.

This historic institution, which pointed the way to modern psychiatric treatment, opened its doors on April 1, 1824, and continued under Dr. Todd

guidance for a few brief years until his death in 833. His ideas were revolutionary for those days, but were gradually accepted, and the humane treatment which he introduced replaced the tragic methods which had prevailed for centuries.

The Institute has become one of the most active hospitals of its type in the world, with 400 beds and over 800 admissions a year. Some years ago leading citizens of the state petitioned the General Assembly to recognize the services of Dr. Todd as a public benefactor, but no action was taken on this proposal. The memorial tablet to be placed in the new home of the State Medical Society will thus become the first formal recognition of the accomplishments of a noted leader in American psychiatry.

Dr. Fulton Lectures in England

Dr. John F. Fulton, chairman of the Department of Physiology, Yale University School of Medicine, recently delivered five lectures at the London School of Hygiene and Tropical Medicine.

He was selected to give the Heath-Clark Lectures on the general subject "Aviation Medicine in its Preventive Aspects: An Historical Survey." The lectureship is an endowment of the University of London.

Dr. Fulton's first lecture, delivered November 5, was entitled "Altitude Sickness and Acclimitization; The History of Oxygen." Subsequent lectures were: "Decompression Sickness: The Genesis of the Tissue Bubble," "Pressure Cabins and Explosive Decompression: The Spring of the Air," "Acceleration and Motion: Blackout and Air Sickness," and "Man and the Machine: Problems of Safety in Flight."

Biographer of Harvey Cushing and Benjamin Silliman, Dr. Fulton was actively engaged in aviation medical research during World War II. At present he is chairman of the National Research Council Committee on Safety in Flight. Under his direction, the Yale University School of Medicine has become a center for aeromedical research since 1940. Experiments have been conducted for the Office of Scientific Research and Development, the U. S. Army Air Forces, and the U. S. Navy.

Middletown Physicians Appointed

Dr. Edgar C. Yerbury, superintendent, and Dr. Benjamin Simon, clinical director, have been named to the staff of the Yale University School of Medicine.

The staff members have been named as assistant clinical professors of psychiatry and mental hygiene.

Starting in December small groups of Yale medical students are to spend a week at the hospital here and will be given what will amount to a practical course in psychiatry and its related fields. The students will live at the hospital for the week and will attend lectures, staff meetings and work and study on the wards during their stay.

Dr. Yerbury will open the lecture course for the students, giving them a talk on orientation, while Dr. Simon will arrange many of the clinical discussions for the students.

Life Medical Unit Elects Dr. Robinson

Albert J. Robinson, M.D., vice-president and medical director, Connecticut General Life Insurance Company, was elected president of the Association of Life Insurance Medical Directors of America at the 56th annual meeting of the association held in New York City.

Dr. Robinson joined Connecticut General Life Insurance Company in 1924. He was appointed assistant medical director in 1925, medical director in 1932, chairman of the underwriting committee in 1941, and vice-president and medical director in 1943.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, NOVEMBER 10 TO DECEMER 10

FAIRFIELD COUNTY

Smith, A. C., Danbury

HARTFORD COUNTY

Harris, Crit, Glastonbury

NEW HAVEN COUNTY

Berneike, R. R., New Haven
Bishop, C. C., New Haven
Roberts, F. W., New Haven

LITCHFIELD COUNTY

Baker, P. G., Winsted

NEW LONDON COUNTY

Friedman, Irving, Colchester

Dr. Osborn Completes 25 Years



STANLEY H. OSBORN, M.D.

Stanley H. Osborn, M.D., on December 1, 1947 completed one-quarter of century as state commissioner of health for Connecticut. He enjoys the distinction of holding this position longer than any of his predecessors with an unequalled record of consecutive appointments. Dr. Osborn is now serving a six year term which will end July 1, 1953.

The enthusiasm with which he took office on December 1, 1922 following his appointment by the then Governor Everett J. Lake, has not diminished through the years. He "thinks, talks and lives" public health and is an ardent crusader for legislation and services which will safeguard and maintain the health of Connecticut's residents.

During his 25 years in office, he has inaugurated, or advocated, many legislative measures conceived in the interests of the health of residents of this State. Although many of these measures have received national recognition, he takes particular pleasure in a bill passed by the 1947 General Assembly. This bill set up an appropriation of $25,000 to permit the state to aid in financing "health districts" for the smaller towns of the State.

Through this act, towns which cannot afford to maintain individual full time health departments may group together to form health districts with full time health officers. Under the bill, the state will finance about 50 per cent of the cost of maintaining such health districts.

Stanley Osborn stands out in health circles as a vigorous and courageous advocate of the best in the field of public health. Always progressive, he has been quick to foresee the implications of certain federal measures which would increase the dependency of the State on the central governmnt. Organized medicine has found him a friend of the finest quality. The individual practitioner need look no farther for a champion. The public may rest assured that as long as Dr. Osborn retains his present position he will continue to serve the best interests of his fellowmen.

Connecticut Mutual's New Medical Assistant

Dr. Richard E. Nicholson has been appointed medical assistant by the Connecticut Mutual Life Insurance Company, effective November 1. He graduated from the Tulane University Medical School in 1942, following which he entered the Army Air Corps. After the war he took a postgraduate course at Cornell University Medical School in New York City, specializing in internal medicine. On completion of this work he became a member of the Medical and Surgical Clinic in Dallas, Texas.

State Health Council Recommended

The formation of a State Health Council is the subject of a recommendation passed at the semiannual meeting of the Connecticut Public Health Association, held in New Haven Wednesday, November 19.

The action followed a discussion of the needs for such a council, led by Professor Ira V. Hiscock, chairman of the Yale University School of Public Health, and Dr. John Feree of the National Health Council. It was contended that the formation of a State Health Council is essential to encourage medical and dental associations, health departments, and voluntary agencies engaged in health work to coordinate their planning for maximum public benefit.

Dr. Bauer Explains World Medical Association



Louis H. Bauer, m.d.

The World Medical Association will press for ınishment of German physicians who were in-ɔlved in war crimes, Louis H. Bauer, president of e Medical Society of the State of New York and :legate to the World Medical Conference recently :ld in Paris, told more than 200 guests at the mid-:ar dinner of the Woman's Auxiliary and the State edical Society the evening of December 4 at the ew Haven Lawn Club.

The speaker recounted the progress of the Paris ɔnference, and declared that the World Medical ssociation will represent more than 500,000 physi-ıns throughout the world. It will seek to ·engthen the position of the medical profession in countries in relation to state governments, medi-l education, and medical specialization, he said.

James R. Miller, president of the Society, and airman of its Committee on Prepaid Medical Care, in announcnig the action taken by the House of Delegates on the proposed program of surgical and obstetrical insurance for employed groups, said that "It is the intention of our Society to begin with this limited program, and to extend it as rapidly as possible to cover more and more conditions, and more and more people."

Remarking that "the movement for voluntary prepaid medical insurance is young," and that it has followed the development of prepaid hospitalization plans because "it is a much more complicated enterprise," he declared that "these plans are now extending all over the country and are growing by leaps and bounds." He pointed out that the rate of growth is already more rapid than that experienced by hospitalization plans.

"The organized medical profession is convinced that voluntary health insurance plans can help the American people obtain sufficient medical care at a cost which they can afford without subjecting them and the profession itself to bureaucratic domination," he told his audience.

"Doctor's Orders"

The Connecticut State Medical Society
On the Air

Every Sunday at 1:15 p. m.

Yankee Network

		Dial Settings
WICC	Bridgeport	600
WWCO	Waterbury	1240
WONS	Hartford	1410
WNLC	New London	1490

Program

October	26	High Blood Pressure
November	2	Winter Skin Care
November	9	Sinus Trouble
November	16	Winter Child Care
November	23	Stomach Ulcers
November	30	Low Back Pain
December	7	Tuberculosis
December	14	Glaucoma
December	21	Asthma
December	28	Alcoholism
January	4, 1948	Plastic Surgery
January	11	Insomnia
January	18	Pneumonia

Dr. Ralph McDonnell Dies Suddenly

Ralph E. McDonnell, clinical professor of dermatology at Yale University School of Medicine and president of the New Haven County Medical Association, died suddenly at his home in Northford on November 24, 1947. As a member of the U. S. Naval Reserve during World War I, Dr. McDonnell was assigned to the investigation of the effects of poison gas on the skin and the development of counter measures. During World War II he was chairman of the New Haven County Medical Defense group.



Ralph McDonnell had been active in local and county medical circles for several years, having served as secretary of the New Haven County Medical Association before becoming president. His cordial handshake and genial smile will be missed by his many friends.

Hospital for Alcoholics in Hartford

Recently land has been purchased and preliminary plans laid for a $425,000, 50 bed, cottage-type hospital for problem drinkers to be built in Hartford under the auspices of the Connecticut State Commission on Alcoholism. The new hospital will be used as a center to study medical problems, to carry on research and to develop effective methods of treatment. Full psychiatric, medical and nursing facilities will be provided and the hospital will be designed to care for problem drinkers both on an inpatient and clinic basis.

Dr. Chipman Goes to Louisiana

Sidney S. Chipman, formerly in the practice of pediatrics in Norwalk and during the past year a student in the School of Public Health, Yale University, has been appointed associate professor of pediatrics at Louisiana State University, School of Medicine. He will be engaged on a fulltime basis and will be director of the postgraduate extension program in pediatrics in that State on a joint appointment of the State University and State Board of Health.

Dr. Parker M. Cort Retires From Aetna

Dr. Parker M. Cort, associate medical director of the Aetna Life Insurance Company, has been retired at his own request. Dr. Cort has been associated with the Aetna Life for twenty years, and, before that, was engaged in the general practice of medicine in Springfield, Mass.

Announcement of Carmalt Lectureship

The Beaumont Medical Club of Connecticut announces that the Carmalt Lecture for 1948 will be given by Joseph Trueta, M.D., D.SC., of Oxford, England, on January 30 at the Historical Library, at 5 P. M., Yale School of Medicine. Dr. Trueta, who is at present associated with the Nuffield Institute for Medical Research, is well known for his contributions to war surgery, especially in the treatment of fractures. Dr. Trutea will speak on Michael Servetus.

The Future of Voluntary Health Insurance in England

As a result of the transference to the Ministry of National Insurance of the administration of cash sickness benefits and the establishment of a National Health Service under the Ministry of Health providing comprehensive medical service for the entire population, the voluntary health insurance movement in England, as represented by the approved societies, is facing the most serious problem in its history. Incomplete returns in September 1947 showed the voluntary insurance membership at the end of 1946 to be 6,465,808 and the membership on the State insurance side 6,742,719. The contribution of the societies furnishing voluntary health insurance, extending in the case of some of them for well over a century, according to the *British Medical Journal* has had scant reward from a government which might have been expected to have treated them differently.

Industrial Health Conference With Management

Modern industrial management is taking positive steps to activate principles of sound human relationships as a basic factor in solving the problems of its working force, John Bunce, general manager of the Pratt and Whitney Division of the United Aircraft Corporation, told members of the Society's Committee on Industrial Health at a dinner given at the company's East Hartford plant on November 19.

In this new approach to the problems of both management and labor, the Pratt and Whitney Division is playing a leading role, Mr. Bunce said, and pointed out that the importance of good employee health and adequate medical service has long been recognized by his company as fundamental to the maintenance of high morale and worker efficiency. The precision manufacturing processes in which the company is engaged demands the highest possible development of human potentials, he declared.

Dr. John N. Gallivan, medical director for the company, outlined the principal features of the medical program maintained for the company's 14,000 employees. Thorough pre-employment examinations have demonstrated their value in assuring that workers are placed in jobs which they are capable of performing without difficulty, he declared. This is especially true, he said, in cases where minor physical defects may limit the capacities of workers when operating intricate and high-speed machinery.

Citing statistical proofs of savings in time and expense which have resulted through the application of a progressive medical program during the past decade, he emphasized that programs of industrial health more than pay their own way, and become an increasingly valuable asset for industry at large.

Toastmaster for the occasion was Dr. Crit Pharris, assistant medical director for the company. Dr. C. Frederick Yeager, chairman of the Committee on Industrial Health, expressed the appreciation of committee members for the efforts of the plant management in arranging details of the conference.

Approximately forty-five company officials, members of the committee, and guests attended the dinner which followed a tour and inspection of the plant. During the tour special attention was devoted to the hospital and medical-aid facilities. The event marked the third conference with industrial management to be sponsored by the committee for the progress of medicine in industry. Similar conferences have been held at the Cheney Mills in Manchester and the American Brass Company in Waterbury.

You'll Find These Policies in Connecticut Hospitals

Connecticut State Nurses' Association most recent survey of personnel policies for institutional staff nurses show differences between public and private hospitals which just about balance each other. If you are on the staff of a state or municipal hospital, your starting salary is most likely to be in the $2,200 to $2,299 group; and in a private, $2,040. In a public hospital, however, your work week usually runs to forty-eight hours, while the average in a private, is forty-four.

Replies, summarized here, come from fourteen state and municipal hospitals and from forty-one private institutions.

Q. What per cent of the hospitals have written employment agreements?

A. 28 per cent of the public, and 35 per cent of the private hospitals.

Q. Is membership in state and national professional organizations one criterion for advancement in positions?

A. Yes, 29 per cent in public, 47 per cent private.

Q. How long is the working week?

A. Forty hours say 8 per cent of the public hospitals. In this group, another 8 per cent work forty-four hours; and 84 per cent, forty-eight hours. Of the private hospitals, 25 per cent reported forty hours; 43 per cent say forty-four hours; and 32 per cent forty-eight hours.

Q. What is the beginning staff nurse salary?

A. Among the state and municipal hospitals, 7 per cent say $2,000 to $2,039; 22 per cent, $2,040 to $2,099; 64 per cent, $2,100 to $2,299; and 7 per cent, $2,400 or more. Private hospitals reported, 25 per cent, $2,000 to $2,039; 33 per cent, $2,040 to $2,099; 27 per cent, $2,100 to $2,299; and 10 per cent, $2,400 or more.

Q. What about maximum staff salaries?

A. Of the publicly financed hospitals, 86 per cent reported $2,400 or more, while only 43 per cent of the private hospitals were in this group.

Q. Does your hospital give a complete physical examination including x-ray?

A. Yes, said 36 per cent of the public hospitals, and 43 per cent of the private ones.

Q. Does your hospital have an annuity pension or retirement plan?

A. State and municipal hospitals report a wholehearted 100 per cent yes. Of private hospitals, however, only 7 per cent say yes; 90 per cent, no; and 3 per cent did not answer.

It adds up: hours are still a weak point, especially on the question of a consecutive eight-hour day . . . and note the replies on retirement plans. They might well be evened up.

First Nutrition Institute

The Connecticut State Department of Health, in cooperation with seven other agencies, sponsored its first Nutrition Institute on November 21 and 22 in New Haven.

Sessions of the two-day institute were held at the Yale University School of Nursing, and participating agencies included the Connecticut State Department of Education, Connecticut Home Economics Association, Connecticut Dairy and Food Council, Connecticut Dietetic Association, University of Connecticut, American Red Cross, and Yale University.

Principal speakers and their subjects were: Dr. Helen S. Mitchell, dean, University of Massachusetts, "Recent Developments in Protein, Minerals, and Energy Metabolism;" and Dr. George R. Cowgill, professor of nutrition, and head of the Yale Nutrition Laboratory, "Recent Developments in the Vitamins."

The annual meeting of the Connecticut Dietetic Association, held at St. Raphael's Hospital during the institute sessions, was featured with an address on "Therapy in Relation to Newer Developments in Nutrition," by Dr. Joseph H. Howard, of Bridgeport.

More Drugs On Sales Tax Exempt List

A new sales tax regulation broadening the base of drugs to be tax exempt under "medicines by prescription," was issued recently by Tax Commissioner Walter W. Walsh, effective immediately.

In addition to liberalizing the definition of prescription medicine, the new regulation adds to exempt items insulin and adrenal cortex.

The regulation explains that such drugs and med cines are of such a character that the proper amour can be determined only by an "initial diagnosis" b a duly authorized medical authority. Such items ar tax free even though the purchaser may not be i possession of the original prescription.

"Medicine by prescription," according to th regulation, "shall mean drugs and medicines com monly known and regarded as such by druggists o pharmacists including biologics, antibiotics, hor mones, and similar medicinal items prescribed fo the specific treatment of disease by persons author ized by the laws of this state to issue prescriptions.

Vitamins are exempt only when purchased o prescription. All refillable prescriptions are ta exempt on subsequent purchases "even though th date of the original prescription may be prior t July 1, 1947."

Such drugs or medicines, the regulation state are also exempt from the tax when purchased by physician, dentist or veterinarian for use by him i his profession.

State Seeks Uniform Fees for Medical Service

The time has now come when the State finds i necessary to "standardize" fees for medical services which now cost the State about $3,500,000 a year

A special committee, suggested by Governor Mc Conaughy, is at work surveying the variety o medical charges paid by State agencies with the ain of establishing uniform fees.

The study will include charges for specific serv ices furnished to State patients by physicians, den tists, oculists, nurses and hospital, as well as fo prescriptions.

In explaining the necessity of the investigation Finance Commissioner James B. Lowell points ou that there is a "wide variance" in the rates som State agencies pay for medical services.

Dr. Cole B. Gibson, superintendent, Underclif Sanitorium, Meriden, was named to head the five man committee, which includes State Health Com misioner Stanley H. Osborn; State Welfare Com missioner Robert J. Smith; Col. Raymond F. Gates Veterans' Hospital Commission, and Edward B Cheater, director, vocational rehabilitation.

Dr. Dobson to State Department of Education

The appointment of Dr. John J. Dobson as chief medical consultant for the Division of Rehabilitation, State Department of Education, was recently announced by Alonzo G. Grace, commissioner of education.

Dr. Dobson will be responsibile for supervision of medical services and physical restoration of disabled civilian adults under the rehabilitation program of the Department of Education.

Born in Toronto, Canada, he received his A.B. and M.D. degrees at the University of Toronto. In 1939 he came to the United States to serve his internship at Lincoln Hospital, New York City, and his residency at Sea View Hospital, Staten Island. He became an American citizen in 1942, and later the same year joined the U. S. Army Medical Corps. His four years of miltary service included two years spent in New Caledonia, New Zealand, and Saipan with the University of Minnesota and Yale University hospital units. Following his separation from the service, Dr. Dobson pursued postgraduate training in medicine at Harvard Medical School.

Connecticut Cancer Society

Campaign chairman of the Connecticut division of the American Cancer Society will be Richard H. Valentine, who is president of the Warren Woolen Company at Stafford Springs. A member of Governor McConaughy's staff, Mr. Valentine served last year as vice-chairman of the Connecticut campaign.

Harry F. Morse of New London, Connecticut, 1947 campaign chairman for Connecticut, will head the division's new executive committee now being organized to give statewide support to the coming campaign.

Business leaders who have so far been added to the group are: Edward Allen, president of Sage-Allen Co. of Hartford and former Mayor of Hartford; Frederick U. Conard, president of Pratt and Whitney Co., West Hartford; Samuel W. Meek, vice-president of J. Walter Thompson Co.—his home is in Greenwich; Jesse Randall of Hartford, president, Travelers Insurance Company; Donald Sammis, vice-president of the Underwood Corp., Stratford; William Rich, president of the R. Wallace and Sons Company, Wallingford; and Herman Steinkraus of Bridgeport, president of the Bridgeport Brass Company.

Richard H. Valentine of Stafford Springs, chairman of the 1948 drive, and Dr. Creighton Barker, president of the Connecticut Cancer Society, will serve as ex officio members of the executive committee.

State Doctors Once Gave Guarantees

Connecticut doctors once had to stand behind their work with a written guarantee, according to a document recently uncovered by the Connecticut Historical Society.

In May 1805, Captain William Brainard, 2d, of Westchester, had his entire family vaccinated for smallpox by a Dr. Vine Utley. Upon payment for the services Captain Brainard obtained the following receipt:

"Received of Captain William Brainard, 2d, thirteen dollars by note being in full for vaccinating himself, wife and children, also his father and mother Brainard, and Amasiah, Orin, Susannah, Roxy, Sally and Dolly Brainard and Ansel Goff, and promise that if either of them shall take the smallpox at any time hereafter to pay all necessary expenses in carrying them through said disease."

The society pointed out that all members of the family lived to a ripe age.

Special Meetings County Associations

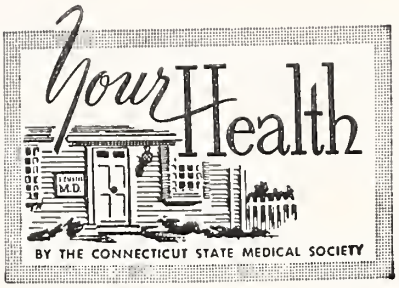
The Hartford County Medical Association will hold its special meeting for discussion of the prepaid medical care plan on January 8. The New Haven County Association will meet on January 15. Up to press time, these were the only county meetings that have been announced.

Western Connecticut Representative

Smith, Kline & French Laboratories, Philadelphia pharmaceutical manufacturers, announce the appointment of Mr. David W. Low, 7 May Street, Hartford 5, as their professional service representative for western Connecticut.

Erratum

The amount of money allotted to the 48 states to cover the cost of the EMIC program up to June 30, 1947 was $124,900,000. On page 873, October 1947 issue of the JOURNAL it was incorrectly given as $214,900.000.



A health column sponsored by the State Medical Society for publication in weekly newspapers.

The column is a joint endeavor of the Committee on Public Health and the Committee on Public Relations. It first appeared in 20 of Connecticut's weekly newspapers on December 19.

SERVICE IS IMPORTANT IN PUBLIC RELATIONS

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Richard H. Grant, Cromwell
New London County, Edmund L. Douglass, *Chairman*
Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, Leonard W. Levine, Ellington
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

State Cash Sickness and Related Bills

The Research Council for Economic Security has published a resume of the cash sickness and related bills introduced into state legislatures during 1947. There were some fifty of these bills introduced in sixteen state legislatures calling for the establishment of compulsory systems of sickness benefits or health insurance. While proposals contained in the bills varied as to administration, benefits, coverage, and method of financing, there was considerable similarity among them. In the majority of instances, plans for the payment of benefits to workers absent from employment on account of illness or accident were designed to supplement existing unemployment compensation systems. Generally speaking the bills fall into six classes: cash sickness benefits—monopolistic type; cash sickness benefits—optional type; cash sickness benefits—voluntary type; unemployment sickness benefits; prepayment medical care; pregnancy benefits.

In the monopolistic type of cash sickness benefits, the benefits and coverage are identical with unemployment compensation and are to be financed by payroll taxes levied on workers and/or employers, varying from 1 to 2 per cent of payroll. A monopolistic state fund (modeled after the Rhode Island plan) is to be created for the payment of benefits; affiliation is compulsory, and there is no provision for alternative voluntary plans. A few bills call for benefits to be paid directly out of unemployment funds. In this category Connecticut had one and Massachusetts three bills introduced.

In the optional type of cash sickness benefits, the benefits, coverage, and financing are similar to the monopolistic type described above. Although a state fund is created, in this type of bill (based on the California system) employers may elect to participate in an approved voluntary plan, i.e., private health insurance or self-insurance. A majority of employees must consent to the alternative voluntary plan, and benefits offered must equal or exceed those from the state fund. One bill of this type was introduced in Massachusetts.

In the voluntary type of cash sickness benefits, the payment of cash sickness benefits is compulsory. However, no state fund is set up, and employers are required to adopt private or voluntary insurance plans subject to state approval and supervision. Massachusetts and New Hampshire legislatures each received one of these bills.

Connecticut had one bill introduced in the unemployment sickness benefits group. Under most existing state laws, unemployment benefits are payable only to unemployed workers who are physically able and willing to work. Bills of this type call for the continuation of unemployment benefits to workers who become ill after registering for or receiving such benefits.

In the prepayment medical care bills, usually covering both workers and dependents, benefits are in the form of medical, surgical, hospital, or other services rather than cash. Such service benefits are to be financed by payroll taxation (varying from 3 to 6 per cent of payroll) and a state fund. Provision is sometimes made for cash sickness benefits in addition to services. The Connecticut legislature received two such bills.

Two bills were introduced in New York, none in New England, to provide for the payment of unemployment benefits to female workers absent from work because of pregnancy.

World Health Organization Fellowship Awards

WHO fellowships have been granted to 190 physicians, nurses, and public health specialists during the first eleven months of the 1947 fellowship program. Ninety-nine awards have been made for study in the United States and Canada, and ninety-

one for work in Europe, Great Britain, and the U. S. S. R.

Fellows come from six European and three Far Eastern countries, as follows: Austria, 9; China, 38; Czechoslovakia, 32; Finland, 10; Greece, 2; Korea, 4; the Philippine Republic, 3; Poland, 57; and Yugoslavia, 35.

Through the fellowships, WHO intends to foster the spread of medical knowledge to the widest possible extent and to aid in rehabilitating public health in the countries most ravaged by war. Fellows are nominated by their governments and follow a plan of study approved jointly by the national government and WHO.

The majority of the awards are made to recognized specialists who are associated with hospitals and medical schools, and will pass on to doctors in their own countries the information gained in their studies. Other fellows will return to responsible positions in the public health administrations of their homelands. A smaller number are young men and women who are preparing for careers in public health. The average duration of the grants is three to six months; those to Chinese students are generally for one year.

During November, twenty-three fellows arrived in the United States. Of those now studying in this country and Canada, more than twenty are enrolled in twelve American universities and four at the University of Toronto. The others are studying with American specialists in hospitals, clinics, and public health departments.

Blood Banks — In California

To clarify a confused situation, perhaps accentuated by the zeal of the American Red Cross to operate its own nationwide system of blood banks, the Council of the California Medical Association has adopted a set of principles for blood banks in California and has advised county medical societies and others of the basis on which these blood banks merit medical approval. Under the program adopted by the California legislature, the State Department of Health would act as "pater familias" in encouraging the establishment and operation of community blood banks, the existing facilities for processing blood would be used to their capacity, and the medical societies would cooperate in the procurement, processing and distribution of blood products. The C.M.A. Council expresses the belief that the functions of the American Red Cross should be confined to the procurement of donors and the transportation of blood.

Minnesota and Colorado Adopt Nurses Wage Schedules

Both the Minnesota and the Colorado State Nurses Associations have adopted a schedule of minimum recommended salaries and employment practices for general staff nurses. In the former state it calls for $200 per month for a 40-hour week beginning in April 1948 while in Colorado it calls for the same salary for a hospital staff nurse working on a 44-hour week. Minnesota recommends increments after certain time intervals, additional pay for evening duty and for night duty (the former more than the latter), additional for tuberculosis, psychiatric or contagious disease nursing. It also provides for a definite health program, vacations with pay, and a retirement plan.

Research Program in Human Reproduction

The first comprehensive program for research in the field of human reproduction has been organized by the National Committee on Maternal Health under the direction of the National Research Council in Washington.

The Council has already established a Committee on Human Reproduction to study needs and then to recommend grants for specific research projects to qualified institutions and individuals.

The Research Council has agreed by contract with the National Committee on Maternal Health and in collaboration with the Planned Parenthood Federation of America to establish a Committee to plan the program of research. The Council will set up research panels for various phases of the work.

These panels will operate in accordance with policies to be established by the newly reorganized board of the Committee on Maternal Health. Formerly an organization of members of the medical profession, it has become a predominantly lay board.

Dr. Haven Emerson is chairman of the National Committee on Maternal Health and the chairman of the new Committee on Human Reproduction is Dr. Howard C. Taylor, Jr., professor of obstetrics and gynecology at Columbia University, College of Physicians and Surgeons. Dean C. N. H. Long of Yale University School of Medicine is chairman of the Research Council's Committee on Research in Endocrinology.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

NOTICE TO FEE BASIS PHYSICIANS

The Veterans Administration will not permit outpatient clinics or fee basis physicians to give ambulatory electroshock treatment to VA patients.

Dr. Hawley Resigns

Major General Paul R. Hawley, who reorganized the medical service of the Veterans Administration under General Omar N. Bradley, on November 24, 1947 announced his resignation as of January 1, 1948. His successor will be chosen by Carl R. Gray who succeeds General Bradley, also on January 1.

In the transforming of the Veterans Administration into an organization suitable to the needs of the prospective 19,000,000 veterans of World War II, General Hawley made extensive changes in VA medical practice, many of which involved basic changes in laws. He broadened clinical treatment, set up a system whereby veterans may be treated privately for various physical troubles with the Government paying the cost, and brought many distinguished members of the medical and surgical professions into VA service as part time consultants.

In accepting General Hawleys' resignation, General Bradley wrote in parts as follows:

"Your program, your policies and your intense personal efforts have assured the nation of the finest kind of medical service for its veterans. Through your own integrity of purpose and insistence upon high medical standards, you pioneered in a brilliantly conceived cooperative program between Government and medicine, a program which has brought health and the promise of happier lives to sick and disabled veterans. As a doctor, soldier and administrator, you have served your country and your fellowmen well."

Medical Group to Help Vets

Organization of a Veteran's Administration Medical Society composed of members of the medical and dental staff of the Hartford VA Regional Office was announced recently by Dr. Edgar D. Prout of Portland, newly-elected president of the group.

Purposes of the VA Medical Society, as outlined by Dr. Prout, are to encourage advanced studies in the various medical specialties and to bring to the society reports of the most recent accepted methods of diagnosis and treatment and to promote the use of these methods for a high type of medical and surgical practice in the VA. The society meets weekly.

Other officers of the VA Medical Society include: Dr. Morris Dressler of Hartford, vice-president; Dr. Glenn P. Speidel of Hartford, secretary; Dr. Patsy M. Fiandaca, of Newington, assistant secretary; Dr. Dressler, chairman of the program committee; Dr. George W. Bassow of Hartford, chairman of the library committee; and Dr. George E. Roch of Willimantic, welfare committee.

VA Mental Hygiene Clinic

The mental hygiene clinic of the Veterans Administration is now operating on a full time basis at 1026 Main Street, Hartford.

The clinic is headed by Dr. Isadore Schnap, formerly chief of the neuropsychiatric service at the VA Hospital in Newington. The staff includes one neuropsychiatrist, two clinical psychologists, two psychiatric social workers, and two attending specialists in neuropsychiatry.

Facilities are available for the outpatient treatment of service-connected neuropsychiatric conditions. Referrals of eligible veteran patients may be made by physicians, social agencies, and hospitals, through the VA Regional Office, Outpatient Department, 95 Pearl Street, Hartford.

Discuss Veterans' Problems

Representatives of 41 state medical societies, the American Medical Association and the Veterans Administration met at the AMA Chicago headquarters Thursday, November 6, to discuss the "VA

Home Town Medical Care Program."

The conference heard a frank discussion of the many problems arising from this program.

A committee, appointed for the purpose of summarizing conclusions, met immediately after the conference with the AMA Veterans Committee. The two groups agreed upon certain basic principles which the Veterans Committee of the AMA could use in presenting a united front for the state programs. The AMA Veterans Committee will also act as a clearing house for problems on policies arising in the various states and will, if necessary, carry the problems directly to the Veterans Administration in Washington.

Enrollment in Home Town Medical Care Plan

As of November 25, 1947, 1,124 physicians were enrolled in the Home-Town Medical Care Plan for Connecticut Veterans as follows:

HARTFORD COUNTY
Total: 324

Avon	1
Bloomfield	2
Bristol	27
Broad Brook	2
Collinsville	1
East Hartford	9
Elmwood	1
Enfield	1
Farmington	1
Glastonbury	2
Hartford	179
Hazardville	1
Manchester	13
New Britain	33
Newington	6
Plainville	4
Plantsville	1
Rocky Hill	1
Simsbury	2
Southington	6
Suffield	2
Thompsonville	3
Unionville	1
West Hartford	15
Wethersfield	4
Windsor	4
Windsor Locks	2

LITCHFIELD COUNTY
Total: 52

Canaan	3
South Kent	1
Lakeville	1
Litchfield	5
New Milford	2
North Canaan	1
Sharon	3
Terryville	2
Thomaston	4
Torrington	21
Washington	2
Watertown	2
Winsted	5

NEW HAVEN COUNTY
Total: 353

Ansonia	9
Branford	6
Cheshire	3
Derby	9
Devon	2
East Haven	3
Guilford	1
Hamden	5
Madison	1
Meriden	33
Milford	9
Naugatuck	9
New Haven	163
North Haven	2
Seymour	2
Shelton	1
Wallingford	12
Waterbury	70
West Haven	13

NEW LONDON COUNTY
Total: 61

Groton	4
Jewett City	2
Lyme	1
Mystic	5
New London	21
Niantic	1
Norwich	20
Old Lyme	1
Taftville	1
Uncasville	2

MIDDLESEX COUNTY
Total: 27

Chester	2
Clinton	2
East Hampton	2
Essex	3
Middletown	14
Moodus	1
Old Saybrook	1
Portland	2

FAIRFIELD COUNTY
Total: 276

Bethel	3
Bridgeport	117
Danbury	18
Darien	6
Fairfield	5
Greenwich	11
Old Greenwich	3
Long Hill	1
Monroe	2
New Canaan	5
Newtown	3
Norwalk	13
Ridgefield	4
Sandy Hook	1
Shelton	5
South Norwalk	9
Stamford	48
Stratford	10
Westport	9

WINDHAM COUNTY
Total: 22

Danielson	2
Hampton	1
Moosup	1
North Grosvernordale	1
Plainfield	1
Putnam	5
Thompson	1
Willimantic	9
Windham Center	1

TOLLAND COUNTY
Total: 9

Rockville	5
Stafford Springs	3
Storrs	1

Veterans Administration

Veterans Administration has explained the effect of Presidential and Congressional action which set limiting dates for service compensation and pension at wartime rates, payable for disability or death in World War II.

Wartime rates are higher than peacetime rates for comparable disabilities; therefore, these limitations, defining service during the war for compensation and pension purposes, become important to veterans and their dependents, VA said.

The actions that govern in the award of these benefits are: (1) the President's proclamation ending "hostilities" in World War II at 12 o'clock noon, December 31, 1946, and (2) Public Law 239 of the 80th Congress, which officially terminated the war on July 25, 1947, for certain purposes.

The need for clarification regarding the effect of these actions stems from the use of different terminology in the various laws and regulations which provide the benefits, VA said.

Generally, to be compensable at wartime rates the death, disability or aggravation of injury upon which a claim is based must have occurred in service between December 7, 1941, and July 25, 1947, both

dates inclusive. While this is the way it will work out in most cases, the law itself is not quite that simple.

Veterans Regulation 1 (a) as amended is the basic law. It provides compensation and pension benefits under several headings:

Part I establishes standards for the award of benefits based on active service while the United States is engaged in war. In order to qualify under this part, which carries the higher rates and gives the veteran the benefit of certain presumptions of war-service connection, the person must have served during the war period prior to noon, December 31, 1946, and the disability or death on which the claim is based must have occurred before July 25, 1947.

Part II of V. R. 1(a) provides benefits for disability or death incurred in peacetime service. Claims of persons who entered service after noon December 31, 1946, are adjudicated in accordance with the provisions of this part. However, under an amendment to the pension laws approved December 19, 1941 (P. L. 359, 77th Congress), such awards are compensable at wartime rates if the injury or death occurred before July 25, 1947.

Except for the higher rates payable where the cause of injury or death is traceable to service prior to July 25, 1947, those entering the armed forces after noon December 31, 1946, are considered veterans of peacetime service for compensation and pension purposes.

The amendment of December 19, 1941, also makes the higher rates applicable to strictly peacetime service if the claim is based on extra-hazardous service, including simulated warfare.

Part III of V. R. 1(a) and other laws provide pensions for dependents of deceased war veterans, and for the veterans themselves if permanently and totally disabled, even though the death or disability is not related to the veterans service. In order to qualify as a World War II veteran under this section, the veteran must have served at least ninety days, some part of which was in the period between December 7, 1941, and noon, December 31, 1946.

Reception services in Veterans Administration hospitals are being abolished to speed active medical treatment of veteran patients.

In the future, all general medical and surgical patients will be admitted directly into active treatment wards, where their case histories, necessary x-rays and other routine examinations will be made. These functions formerly were conducted by the reception services pending assignment of patients to treatment wards.

In tuberculosis hospitals, new patients will enter diagnostic and classification units where they will be put to bed immediately regardless of past diagnoses or apparent status of physical well being. This procedure gives the doctors an opportunity to study temperatures, pulse, respiration and other vital processes while patients are in absolute rest. Active treatment as determined by doctors will begin without further delay.

In neuropsychiatric hospitals, acute (intensive treatment) services are being established with these units having all facilities needed for treatment of acute neuropsychiatric disorders in all categories of behavior and diagnoses.

Here therapeutic needs will be determined promptly and treatment programs started without delay. Patients who improve or show prospects of improvement will be retained in this service until trial visit, discharge or need for continued treatment becomes evident.

The number of World War II veterans receiving hospital care from Veterans Administration reached an all time peak of 52,032 on August 1, the latest date for which official figures are available. This is an increase of nearly 100 per cent over the total for two years ago (August 1, 1945), when 21,271 War II veterans were receiving VA hospital care.

The increase has been steady since that time. On January 1, 1946, the total was 25,202; on July 1, 1946, it was 37,496, and on January 1, 1947, it had gone up to 49,204.

The 52,032 War II veterans receiving VA hospital care last August 1 represented about one half of the 105,432 veteran patients in VA hospitals and in non VA hospitals, under contract to provide medical care for veterans, on the same date.

A breakdown of the 105,432 total, by period of service, follows:

World War II	52,032
World War I	47,417
Spanish-Ameriean War	2,881
Civil War	4
Other Wars (Indian Wars, etc.)	138
Regular (Peaeetime) Establishment	2,732
Retired Offieers and Enlisted Men	228
Total	105,432

HOUSE OF DELEGATES, CONNECTICUT STATE MEDICAL SOCIETY

New Haven, December 4, 1947

The 1947 semi-annual meeting of the House of Delegates was called to order at 3:30 P. M. on Thursday, December 4, 1947 by James R. Miller, president.

The following budget for 1948 was adopted as recommended by the Council and the assessment of dues fixed at twenty dollars ($20).

Estimated Income from Dues	$45,500	
Estimated Income from JOURNAL	19,000	
Miscellaneous Income	1,200	
Total Estimated Income		$65,700
Budget Allotments:		
General:		
Chairman of Council	$ 300	
Council Expense	400	
Treasurer's Contingent Fund	1,200	
Committee Allotments:	1,725	$ 3,625
Public Health	$ 50	
National Legislation	100	
Industrial Health	50	
Phar. Joint Committee	100	
Medical Care of Veterans	100	
New England Council	100	
Military History	600	
Rural Health	100	
Comm. Org. and Objectives	300	
Prepaid Medical Service	100	
Tumor Committee	50	
Workmen's Comp.	75	
Secretary's Office:		
Personal Services	$21,500	
Rent	1,200	
Miscellaneous	3,000	$25,700
Treasurer's Office:		
Personal Services	$ 600	
Auditors	480	
Treasurer's Agent (Bank)	150	
Postage and Printing	250	$ 1,480
Journal:		
Personal Services	$ 7,500	
Rent	900	
Miscellaneous	1,200	
Mfg. Cost and Distribution	18,000	$27,600
Public Relations:		
Personal Services	$ 4,500	
Travel, Printing, Postage, etc.	1,000	$ 5,500
Building Fund:		
Taxes and Maintenance	$ 500	
Solicitation Expense	350	$ 850
Total Budgeted Allotments		$64,755
Unexpended Budget Allotment		$945

The following amendments to the by-laws of the Society were recommended by the Council and approved by the House of Delegates:

Article XI, Sec. 1, Par. 4, which now reads "The dues of any member may be remitted by majority vote of the House of Delegates" to be amended to read:

"The dues of any member may be remitted by vote of the Council on recommendation of a County Councilor."

Article XI, Sec. 1, Par. 3, which now reads, "Members who have been in good standing in the Society for 40 consecutive years or who have attained the age of 68 and shall have been members of the Society for 15 years immediately preceding, shall, upon written request addressed to the Treasurer of the Society, be exempt from further payment of dues and shall continue as active members of the Society enjoying all rights and privileges," to be amended to read:

"Members who have been in good standing in the Society for 40 consecutive years or who have attained the age of 68 and have been members of the Society for 15 years immediately preceding shall be exempt from further payment of dues upon written request addressed to the Treasurer of the Society by the Secretary of the County Association in which the physician seeking exemption is a member and shall continue as active members of the Society enjoying all rights and privileges."

INTERIM REPORT OF THE JOINT CONFERENCE COMMITTEE OF THE CONNECTICUT STATE MEDICAL SOCIETY AND THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

1946-1947

MEETINGS

Our first report included the March 5 meeting and all meetings prior to that date. Since March 5 the Joint Conference Committee has met in New Haven on May 14, in Waterbury on July 9, and in Westerly, R. I., on October 5.

OUNTY ORGANIZATION

Although county groups have been functioning with some uccess in the Hartford and New Haven, the JCC now as under advisement a proposal to re-organize the county roups. It has been suggested that one member of each epresented association be chosen to supervise each county f the state.

ESOLUTIONS

The JCC would like to report that the resolution conerning the use of prescription blanks bearing the pharacist's name thereon and mentioned in our previous report s now a regulation of the State Pharmacy Commission. he Committee respectfully requests that the Connecticut tate Medical Society exert its influence to make this regulaion effective.

ESOLUTION ON COUNTER-PRESCRIBING

"It is not within the scope of the pharmacist to diagnose r prescribe. Counter prescribing, in its broadest sense, as istinguished from dispensing, is both illegal and unethical, xcept as emergency first aid. It is altogether unfair to the ublic, who, through a false sense of security, may be exosed by such practice to all the dangers attendant upon nproper diagnosis and discredited or improperly applied herapy." This resolution has been supplemented by the ollowing explanatory remarks, "Emphasis is laid on *disensing* in contradistinction to *prescribing* in order to avoid nterfering with the privileges of the pharmacist to dispense r sell over the counter any article called for and his reedom to describe its merits and explain its uses generlly but avoid specific recommendations. The emergency lause preserves the human rights of the pharmacist as an ndividual to render emergency first aid, especially since the ublic has learned to look to the drug store as a first aid tation. But there, too, emphasis is laid on the urgency and ot the convenience of the situation."

HYSICIAN'S SAMPLES

"The Joint Conference Committee of the Connecticut tate Medical Society and the Connecticut State Pharmaeutical Association is of the opinion that a procedure praciced by some physicians, namely, the distribution of samples f products left with them in their original containers to heir patients for medication, is unprofessional. If physicians re desirous of utilizing these samples for such a purpose, hey are requested to remove the original label from the ackage or place them in different containers."

UBLICITY

The JCC is of the opinion that the work of its groups s not receiving sufficient publicity. A permanent sub-comnittee consisting of Dr. W. B. Smith of Hartford and Mr. ouis E. Kazin has been appointed for the purpose of nterviewing all interested persons to expedite publicity eleases.

OMMITTEE ON FOODS, DRUGS, COSMETICS, AND DEVICES

The Committee feels there is a need for the formation f a Connecticut Committee on Foods, Drugs, Cosmetics, nd Devices. Inasmuch as at this point sub-committees are n the process of merely formulating tentative proposals or such a group, the JCC will withhold any further report t this time.

SUMMARY

An active liaison has been established between Connecticut's official agencies directly concerned with pharmacy and medicine, namely, the Food and Drug Division, State Health Department, and the Pharmacy Commission. The JCC has been informed that the State Health Department is vitally concerned with the number of irregularities in the writing and refilling of narcotic prescriptions. This department will undertake an educational campaign during the year which campaign will be supplemented by the JCC.

W. T. Salter, M.D., Chairman

REPORT OF THE CHAIRMAN OF THE COUNCIL

Mr. President and Gentlemen of the House of Delegates:

It is again my privilege as Chairman of the Council to bring you an account of our stewardship for the period since the annual meeting in April.

It is with pleasure that I call to your attention the unselfishness and loyalty of your councillors who devote so much time and effort to the service of medicine in Connecticut.

In general the committees, appointed by the council on authorization of the House fo Delegates, have functioned well. We are indebted to these men.

One of the sad features that constantly confronts the council is the unwillingness of some men in the society to act on committees when requestd to do so. It makes the work of the council increasingly burdensome.

The committee appointed to study the compensation laws I hope will make a progress report today. This is a controversial question. It is of great importance to the society. It should be settled with the chief thought in mind of what is best for the patient. Whatever is best for the patient is best for medicine.

The building committee continues to make sure but slow progress. Dr. James D. Gold, the chairman, has spent a great deal of time and effort on this project and it is with pleasure that I call this to your attention. I believe a report of progress will be made here today.

The large committee, recommended by the House of Delegates at the annual meeting to study the objectives of the organization, has been hard at work. It is a big problem and has been time consuming. We are indebted to the men willing to undertake this study.

The annual meeing at Hamden was a very great success. It becomes increasingly apparent to the council that the difficulties encountered in conducting an annual meeting are almost insurmountable. Housing, food, meeting places and rooms for exhibits are almost impossible to find in one area.

The annual meeting in 1948 will be held in Fairfield. Preparations are already underway. The council looks forward to this with the hope that it will be one of our most successful meetings.

The program presented at the Clinical Congress was excellent. The attendance was not as good as in some other years. This is difficult to understand. The Council and the Clinical Congress Committee intend to review this and remedy it if possible.

During the summer months the executive committee of the council, made up of the President, President-elect, Secretary and Chairman of the Council, carried out the duties of the council.

The council has appointed a committee to study the medical examiner system in Connecticut. The present coroner system is antiquated and in my opinion hasn't any place in a progressive society.

A committee has been appoined to establish minimal standards for cancer detection centers. This is a must under existing conditions. On the one hand society is demanding it and on the other hand it must be done with great discretion and again with consideration of what is best for the patient.

Your financial position is sound. The present by-laws provide that the council shall be the financial agent of the society. While this by-law prevails and while I continue as chairman of the council I promise to do my utmost to keep it so.

Under existing laws our employes are not covered by social security. The council has requested the committee studying the objectives of the organization to make a study of the question of retirement plans.

Many of the men in this House of Delegates have served many times before. You have heard me make praiseworthy statements of the loyalty of our hearquarters staff. I do so again with pleasure and privilege. I call to your attention particularly the accomplishments of Dr. Grace Mooney and Mr. James Burch.

My report would be incomplete were I not to say a word about an office and a man. The office—the secretaryship of this society. It is the hub of all activities of the society. It constantly stimulates the members to greater and better activities for the good of the society. New thoughts originate here. Policies established by the House of Delegates are carried out here. All of the thousand and one things necessary for the proper functioning of this organization are done here. The man—Dr. Creighton Barker who has filled this office with devotion, zeal and untiring effort. Ours should be daily prayers of thanksgiving for the years he has been with us, and also ours should be daily prayers asking God to continue him with us for many more years.

T. P. Murdock, M.D.

SEMI-ANNUAL REPORT OF THE COMMITTEE ON STUDY OF THE ORGANIZATION AND OBJECTIVES OF THE CONNECTICUT STATE MEDICAL SOCIETY

Mr. President and Members of the House of Delegates:

I have the honor to present, for its members, the following report of the Committee on Study of the Organization and Objectives of the Connecticut State Medical Society for the period ending December 1, 1947. This constitutes the second interval report of this Committee.

By vote of the House of Delegates on December 30, 1946, the president of the Society was directed to "appoint a Committee consisting of the elected councillor from each county and in addition one other member from ea county." Under this authority, the president appointed t following gentlemen to constitute the committee:

Fairfield County: Dr. Samuel F. Mullins, Councillo Dr. Oliver L. Stringfield.

Hartford County: Dr. D. C. Y. Moore, Councillor; D Arthur B. Landry.

Litchfield County: Dr. Floyd A. Weed, Councillor; D Thomas J. Danaher.

Middlesex County: Dr. Harold A. Speight, Councillo Dr. Frank H. Couch.

New Haven County: Dr. Herbert Thoms, Councillo Dr. Courtney C. Bishop.

New London County: Dr. George C. Gildersleeve, Cou cillor; Dr. Charles G. Barnum.

Tolland County: Dr. Charles T. Lamoure, Councillo Dr. William Schneider.

Windham County: Dr. Karl T. Phillips, Councillor; D William M. Shepard.

Since these original appointments, there have been tw changes of membership in the committee. Following t untimely passing of Dr. D. C. Y. Moore of Mancheste Dr. C. Charles Burlingame succeeded him as councill from Hartford County and assumed his place in this con mittee. Upon his election in April 1947 as councillor fro Fairfield County, Dr. Berkley M. Parmelee succeeded D Samuel F. Mullins.

Two general meetings of the committee as a whole we held during the early months of this year for the purpos of organization, orientation and general discussion of t problems at hand. The advice and counsel of the presiden executive secretary and council of the Society was soug and obtained at these meetings. Thereafter, the steerin committee under the leadership of Dr. Landry undertoo the task of organizing the specific material to be studie the designation of multiple subcommittees for special stud and the assignment of study subjects to these sub-commi tees. Since that date, these subcommittees have worke faithfully and well. According to prior schedule, the da collected by these study groups and the recommendatio derived therefrom have been presented for final action t the regular meetings of the committee as a whole; thes have been held at approximately three months intervals. I all, four meetings of the entire committee, one meeting c the steering committee and an untold number of meetin of the subcommittee study groups have been held. T defray expenses entailed by this committee, the counc approved an appropriation of $300; to date this allotmer has been overexpended in the amount of $12.18.

During the year now concluded, the committee as a whol has received subcommittee study reports concerning th following general titles:

1. The Organization of the Council.
2. The Committees of the Society.
3. The Connecticut State Medical Journal.

The data collected by these subcommittees with its con clusions and/or recommendations have been discussed a length by your committee. In many instances final actio of the committee has been taken; in certain instances, speci subject matter has been referred back to the proper sub committee for further study.

A considerable field remains to be surveyed. This future udy, part of which is already in progress, will include nong other subjects, the following specific items:

1. The organization and function of the central offices of ie Society.
2. The financial structure of the Society.
3. The relationship of the Society to the Community.

Cognizant of its responsibilities in the task assigned, your ommittee has elected to explore the many and diverse athways of its problem with deliberation and without aste; it is the sincere conviction of the committee that its onclusions will be thereby more realistic, more timely, and iore intelligent. It may be anticipated that the committee's nal report and recommendations concerning the subject iatter now at hand will be ready for presentation at the nnual meeting of the House of Delegates in the spring of 948.

Respectfully submitted,
Courtney C. Bishop, M.D., Chairman

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS MARCH 1 TO DECEMBER 1, 1947

The last report concerning public relations was prepared or the 155th annual meeting of the Society in April. Since nat time activities of the section have increased steadily.

Accomplishments during this nine month period include ne inauguration of a weekly radio program; the writing of nore than 70,000 words for newspapers, organization maga-ines, and radio news services; and the preparation of a eries of health columns for publication as a regular feature n Connecticut's weekly newspapers.

More complete utilization of modern communications nedia is the objective of this phase of the program. Another bjective is the increase of editorial support for the ideals nd goals of medicine.

For the public at large, our present program is attempting o (1) offset the effects of propaganda inimical to the best nterests of medicine and the people, and (2) furnish posi-ive and accurate information to the people concerning the chievements of their physicians.

Following is a more detailed account of the Society's ublic relations activities:

RADIO

A subject of study for more than a year, the use of radio n the interests of Connecticut medicine became an actuality on Sunday, October 26. Following approval by the Com-nittee on Public Relations and the Society's Council, the adio program "Doctor's Orders" was inaugurated on that date, and is continuing each Sunday, at 1:15 P. M.

The program is broadcast over the stations of the Yankee Network, which include WONS in Hartford, WICC in Bridgeport, WWCO in Waterbury, and WNLC in New London. The first portion of the 15-minute program is a dramatization of a health problem, and this is followed by interviews with members of the State Medical Society in the four station areas. This constitutes valuable local con-trol of medical information.

Audience response to the program has been growing rapidly, and there is every indication that its influence will continue to spread. At present the program is a public serv-ice venture, and the Society bears none of the costs for radio time, production, or rehearsals. It is anticipated that in the future these costs, which are considerable, will be absorbed by sponsors acceptable to the county medical associations concerned.

PUBLICATIONS

The writing of medical news has been a continuing activity. Since March of this year, releases have been writ-ten as follows: for the daily and weekly press, 59 releases, average length 300 words; for the CONNECTICUT STATE MED-ICAL JOURNAL, 99 releases, average length 350 words; for the *Journal of the American Medical Association*, 25 releases, average length 325 words; and for the *Connecticut Phar-macist* and other journals, 11 releases, average length 500 words. The total of all releases and special articles for the period numbers 194, and the average length was 369 words. This constitutes slightly more than 71,000 words of medical news and information written during the period.

Newspaper coverage indicates that our releases are being accorded good attention by editors, concerning both publi-cation and placement. A number of releases have received front page spot.

Clippings of releases published and now on file in the public relations section total 2,052 column inches for the past nine months. This is equal to 102 newspaper columns of standard 20 inch length, or 12.7 complete newspaper pages. As an average, this amounts to 1.4 newspaper pages per month. Because of certain mechanical limitations, it is customary among clipping services to guarantee only 90 per cent of complete recovery of all releases published. Therefore, the above figure might be extended by 10 per cent.

An increase in the number of newspaper editorials con-cerning the profession has been noted during the period. Clippings of 17 editorials were received, and space devoted to these totalled 204 column inches. This represents 10.2 full newspaper columns. It is felt that this is significant because editorials furnish a barometer of editor interest and motiva-tion.

Clippings show that the information service for editors which the section has been operating since last January is now producing tangible results. Details of the service are mentioned in the following section of this report.

SPECIAL PROJECTS

In the category of special projects are included such activities as the development of the newspaper health column; information service for editors; employee health conferences with industrial management; promotion of the Home-Town Medical Care Plan for Connecticut Veterans; promotion of rural health; Speakers' Bureau; and coopera-tive endeavors with other organizations.

Health Column—Entitled "Your Health," the column which has been prepared for weekly newspapers is a joint enterprise with the Society's Committee on Public Health. Medical information for inclusion in these columns is fur-nished by a subcommittee of this group, under the direction of Dr. Joseph I. Linde. A standard heading for the columns has been designed, bearing the name of the State Medical Society, so that publication will be uniform in all news-papers. The first column will be published the week of

December 15, after which it will be continued as a regular weekly feature.

Editor's Information Service—Our information service for newspaper editors comprises the mailing of pertinent studies concerning health and medical care at 30-day intervals. This periodic mailing is supplemented whenever important information becomes available which merits editorial presentation.

Industrial Health Conferences—The Committee on Industrial Health has now held three half-day meetings at industrial plants, followed by conferences with management concerning problems of employees health. The most recent conference was held at the Pratt and Whitney Division of the United Aircraft Corporation in East Hartford on November 19. Other conferences have been held at the Cheney Mills in Manchester, and at the American Brass Company in Waterbury.

The public relations section has cooperated with the committee to promote industrial health with the public relations officials of the companies concerned, and with newspapers in their communities.

Veterans' Medical Care—The Home Town Medical Care Plan for Connecticut Veterans was named in September, 1946, following careful study of the new problems being faced in the treatment of the large number of World War II veterans. The name has proved popular and has been widely adopted.

The writer has now served for some time as coordinator of veterans' affairs for the Society, under direction of the Committee on Medical Care of Veterans. The medical care plan has been promoted through the press, the CONNECTICUT STATE MEDICAL JOURNAL, the *Connecticut Pharmacist*, and through contacts with other organizations.

Rural Health—Last July, when the Committee on Rural Medical Service arranged New England's first conference on rural health, the public relations section promoted the event with releases to newspapers, farm journals and other publications, and preparation of material for radio use. A quantity of literature pertinent to rural health was also obtained and distributed at the conference, and a summary of the committee reports was written and mailed to organizations and individuals.

Speakers' Bureau—Because most organizations plan their programs a year in advance, requests for speakers have not been numerous during the the period of this report. It is anticipated that after the first of the year, when program chairmen start planning for their meeting of the following winter season, requests for this type of service will increase.

Other Organizations—Cooperative endeavors with other organizations have established mutually helpful relationships. A full account of these activities would be too lengthy for the purposes of this report, but it may be of interest to designate the organizations concerned. These include the Connecticut Pharmaceutical Association; Veterans Administration; Connecticut Cancer Society; Connecticut Rehabilitation Association; Connecticut Conference of Social Work; Red Cross; Connecticut State Federation of Women's Clubs; Connecticut Society for Crippled Children and Adults; and the Connecticut Tuberculosis Association.

Respectfully submitted,
James G. Burch

REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

1. MEDICAL FEES:

Your committee has considered the subject of medical fees on various occasions and has decided for the present to keep them as originally settled although request from Washington has been received asking for readjustment of some of the fees. These were all carefully considered at the time of the first agreement and there is now no reason to make any particular change. Your committee, therefore, has not indicated that it will approve of individual changes of fees to meet the specific requests of the Central Office in Washington, D. C.

The Connecticut County Medical Associations have been appraised of this request from Washington and have been asked to give their opinions. From four of the counties in Connecticut a report has been received, but none as yet have come in from the other four.

A meeting of your committee will take place again on December 10, at which time fees will be reconsidered and it is hoped that by then there will be a complete report from the various county societies.

2. PARTICIPATING DOCTORS:

Eleven hundred and twenty-four doctors, from a total membership of 2,350 of the Connecticut State Medical Society. are now participating members of the Veterans Administration Home Town Medical Plan. All of the members of the Connecticut State Society are not practicing and the 1124 does not include most of the full time VA medical personnel. It can be stated, therefore, that approximately half of the total number of practicing doctors in the State of Connecticut are now available to the VA for individual examinations and treatments.

3. VETERANS ADMINISTRATION MEDICINE IN GENERAL:

The plan for medical care of the Veterans as invisioned and enacted by Dr. Paul Hawley, chief medical director, has been in process of formation for the past two years. The program has had the approval of doctors and their societies throughout the country, including the American Medical Association, Medical Schools and the organization of University Medical School Deans. The care which is now provided *in hospitals* for veterans is of a very good caliber and further improvements are being instituted. The weak spot in the entire program at the moment is the medical service provided in the regional offices. This has been a subject of much discussion in Washington and attempts are now being made to strengthen this branch of the service.

The members of this society have had an opportunity to participate in a broad plan of medical care for a sizable group of the American population. It has been essentially a doctors' program and has given organized medicine in this country a chance to show what can be done with the central government providing the necessary financial assistance. What changes will be made with the new administration of the Veterans Administration central office remain to be seen. We shall know more about this in the coming months.

Norton Canfield, M.D.,
for the Chairman,
Samuel Rentsch, M.D.

Report of the Committee on Prepaid Medical Care

One year ago at the December meeting of the House of Delegates your committee reported fully on the situation up to that time and made recommendations which were adopted. It obtained from the House of Delegates authorization to proceed with the formulation of a definite program. Specifically your committee was authorized to examine and to approve on behalf of the Connecticut State Medical Society contracts covering medical and hospital benefits submitted to it by insurance companies licensed to operate in Connecticut. Your committee was instructed to be alert to observe:

(1) That the contracts which it has approved are promoted without extravagant or misleading statement.

(2) That enrollment practices are sound.

(3) That free choice of physician is maintained.

(4) That complaints and difficulties are promptly and satisfactorily adjusted.

The committee was authorized subject to approval by the Council to appoint Boards of Review to provide satisfactory adjustment of complaints.

The committee was instructed to report annually to the House of Delegates on the extent to which the people of Connecticut are covered by medical and hospital insurance, and on the agencies which write such contracts and in particular to report on progress in developing benefits for medical as well as surgical and obstetrical illness. It is the intention to make this report at the annual meeting of the society.

During the past year your committee and various members of it have conferred with representatives of insurance companies, with insurance commissioners, and with representatives of the Council on Medical Service of the American Medical Association. Particularly close cooperation was had with representatives of the Rhode Island State Medical Society. It should be noted that Wisconsin State Medical Society is interested in a similar program and considerable interest has been voiced by representatives of the Maine Medical Society.

The Rhode Island State Medical Society's House of Delegates has already met and adopted the program which was presented by its committee. Reprints of this program have been distributed to the members of the House of Delegates of this society for their information. Since these programs have been worked out as it were in parallel, though they differ somewhat in detail, and since basic considerations have been discussed so admirably in the Rhode Island presentation, the report of this committee is made easier. It will be noted that certain changes of a minor nature have been made and here and there some of significance.

Schedule A as presented herewith is a statement of objectives and principles of the Connecticut State Medical Society's Program of Voluntary Prepaid (non-occupational) Surgical and Obstetrical Insurance. Your attention is called to paragraph 5 which sets the income levels, below which indemnities will serve as full payment of the fees of participating physicians. These limits, as will be noted in the last sentence, are subject to change by the Society from time to time as warranted by conditions and experience. The basic principle of these income levels is that a guarantee is made to those of the smaller incomes that they will not be charged more than the specified indemnity. Underlying this consideration is the fact which weighed heavily in the judgment of your committee in establishing these levels, that if they are too low the program will not prove attractive to prospective purchasers and if they are too high they will not obtain support of enough physicians. These income levels therefore represent the compromise which your committee believes is wise and safe to serve until we gain enough experience to show that they should be modified.

Schedule B, in the main is identical with that which was adopted by the Rhode Island State Medical Society. The indemnity schedule is slightly more liberal than that which is commonly offered by insurance companies at the present time but it realistically recognizes present conditions.

Your committee differs with the opinion held in Rhode Island. It believes that an assistant fee should not be added but that it should be paid by the surgeon directly. If the total indemnity is not enough, it should be elevated. A separate assistant fee might encourage abuse. It would seriously complicate our present residency training programs and would materially increase the cost to the subscriber.

Your committee feels that for the present it is wise not to include x-ray benefits in this schedule. In the first place it is desirable to start with as simple

a contract as possible so that the program may firmly establish itself. Second, your committee recognizes the extreme complexity of the whole x-ray situation. It has not been the habit for many years for many roentgenologists to send their own personal bills. As soon as a method can be devised by the roentgenologists for the inclusion of a proper x-ray indemnity schedule it can be added. Relationships with Blue Cross and the hospitals in this regard are too complicated for us to risk the success of the whole program by undertaking too much at first.

Schedule C is the form which participating physicians will sign indicating that they undertake the obligations of the program and agree to abide by the rulings of the Society's committee.

Schedule D, which your committee has included in this program is a form which has been in use in Wisconsin. This is felt to be extremely valuable for it accentuates the physician-patient relationship and promotes as far as possible a correct understanding of the fiscal relationship at the start. The execution of this form guarantees that no third person is to come between the physician and his patient.

Your committee feels that the overwhelming majority of physicians in Connecticut will treat their patients fairly. The success of this program will depend on how well it works at this point. It is in the interest of the profession to provide ready means for review of injustices and misunderstandings and your committee has no illusions concerning the importance of this duty to see that good public relations are not spoiled by the actions of an inconsiderate few.

As a result of our conferences with many representatives of the insurance industry we are confident that as soon as our program is announced a large number of the companies licensed to do this form of business in Connecticut will develop and aggressively sell on a competitive basis a program providing the specified coverages.

In this connection we are hopeful that rapid progress can be made through incorporating these benefits into the hundreds of existing group insurance plans in the state as well as through the adoption of the program by many new groups. We are of course optimistic that ways and means will be found to market this type of insurance to individuals and families on a large scale, but the underwriting and sales problems to be solved are obviously more difficult than in the case of groups of employees.

Your committee urges speedy adoption of this report and authorization for the committee in the development of the program to exercise judgment on details within the broad outlines of the policies of this program.

It would not be enough, however, for this House of Delegates to adopt the program and to give it no more than lip service. It must be adopted with full determination to carry its operations to all corners of the state and to enlist in its support every member of our Society.

James R. Miller, *Chairman*
Cole B. Gibson
Joseph H. Howard
Thomas P. Murdock
Herbert Thoms
Creighton Barker, *Secretary*

SCHEDULE A

OBJECTIVES AND PRINCIPLES OF THE CONNECTICUT STATE MEDICAL SOCIETY'S PROGRAM FOR VOLUNTARY PREPAID (NON-OCCUPATIONAL) SURGICAL AND OBSTETRICAL INSURANCE.

The Connecticut State Medical Society (hereinafter referred to as the "Society") establishes as its objectives:

(1) To increase the extent to which voluntary insurance against the cost of medical care is made available to the people of Connecticut;

(2) To increase the effectiveness of such insurance through the voluntary cooperation of its members;

(3) To establish minimum standards under which such insurance will receive the commendation of the Society;

(4) To promote free competition in the sale of such insurance;

(5) To safeguard the physician-patient relationship;

(6) To maintain and constantly improve the high standards of medical care rendered under insurance programs.

In order to attain such objectives the Society hereby sponsors a program of Prepaid Surgical and Obstetrical Insurance on the following principles:

(1) Injuries and diseases compensable under the Workmen's Compensation Law will not be covered in this program.

(2) The attached Master Schedule of Surgical Indemnities shall serve as a standard for use in connection with this plan. Such Schedule is subject to change by the Society upon reasonable notice, as conditions and experience warrant.

(3) The Society shall make a determined effort to obtain the widest possible participation in the plan by its members. Participation shall mean the doctor's agreement with the Society to accept the amounts in the Indemnity Schedule as full payment for the procedures listed therein for persons coming within the eligible income group, and their dependents, insured under policies approved by the Society, as hereinafter set forth; provided such persons authorize that

he payments be made by the insurance carrier direct to he physician.

(4) The Society shall endeavor to interest all duly licensed nsurance companies in underwriting this program.

(5) Persons who shall receive surgical service for the ndemnity fee listed in the Master Schedule of Surgical ndemnities include (a) individuals whose total incomes do ot exceed $2,000 per year and whose total aggregate amily incomes do not exceed $3,000 per year, and (b) ndividuals with dependents whose total aggregate incomes o not exceed $3,000 per year, at the time of disability. Persons whose total incomes exceed such limits shall have uch indemnity fee applied towards the physician's total bill vith such persons liable for any additional fee charged by ne physician. These income limits are subject to change y the Society from time to time upon reasonable notice s warranted by conditions and experience.

6) Each insurance company desiring to have its policies pproved under this program shall submit to the Society ne policy form or forms it proposes to offer with the ndorsement of the Society and such forms may include overage and benefits in excess of that required by the ociety provided, however, that the Society's approval shall e limited to surgical and obstetrical benefits and certain nesthesia services and that no policies shall be sold under nis program before January 1, 1948.

(7) The Society shall review the policy forms and, if finds that the Indemnity Schedules and other provision n such policies, except as hereinafter noted, meet the mini- num standards of coverage and believes that the promotion nd sale of such policies will contribute toward the attain- nent of the objectives of its program, the Society may rant its consent to the use by the company of the state- nent "The Surgical, Obstetrical and Anesthesia Benefits in nis Policy are Accepted and Approved by the Connecticut tate Medical Society" on such policy forms and in its dvertising and promotional literature to be used in connec- on therewith. For the sake of simplicity, some of the less requent types of procedures may be omitted from the rinted fee schedule in such policy forms, with the under- anding that the attached Indemnity Schedule shall govern or unlisted procedures.

(8) All advertisements and promotional literature involv- ng the Society's name shall be submitted to the Society at east fourteen days before its intended use and the use of ny such material shall be subject to disapproval of the ociety on reasonable notice to the company.

(9) The Society shall be under no obligation to review ne premium rate or rates of the policies submitted for its pproval under this program, since it is the desire of the ociety to permit such rates to find their natural levels nrough competition. However, the Society, may request ach company to supply it with the rates at which the olicies are offered to the public and to keep it advised f changes in premium rates.

(10) An insurance company whose policies are approved nder this plan shall not interfere with the insured's free hoice of a physician.

(11) The Society shall not interfere with an insurance ompany's rights and obligations under the terms of the olicy form endorsed by the Society, provided, however, that payments made by the insurance company under such policy for procedures not listed in the attached Indemnity Schedule shall be subject to review by the Society.

(12) An insurance company whose policies are approved under this plan may at any time, upon fourteen days' prior written notice to the Society thereof, cease to issue its policies with the Society's endorsement. Thereafter, such company shall not use the endorsement of the Society on any new policies issued or in advertising or promotional literature in connection therewith. In such event the Society's endorsement of all outstanding policies of said company shall nevertheless continue until the next following anniversary date of issue of such policies.

(13) The Society may at any time, upon fourteen days' prior written notice to an insurance company, withdraw its consent to the use of its endorsement on any policy form and in advertising and promotional literature in connection therewith. In the event of such withdrawal (a) the company shall cease forthwith to use such endorsement on all new policies on such forms and in advertising and promotional literature in connection therewith; (b) the Society's endorsement of all outstanding policies of said company on said form shall nevertheless continue until the next following anniversary date of issue of such poliices; and (c) the company shall have no cause of action against the Society except upon proof of malice.

(14) A Prepaid Medical Insurance Committee of the Society shall confer with the insurance companies on questions which arise in connection with this program; shall take appropriate action upon administrative matters and complaints of persons insured or participating doctors, and, if so authorized, shall act in the name of the Society to carry out the principles of this program.

SCHEDULE B

MASTER SCHEDULE OF SURGICAL INDEMNITIES

Including usual pre- and post-operative care

I. MULTIPLE PROCEDURES

When more than one operation is performed at one time, payment will be made for each in accordance with this Schedule, subject to a maximum total of $150. Furthermore, the maximum total with respect to all operations due to the same or related cause which are performed during a continuous period of disability shall be $150. For this purpose all procedures performed through the same incision shall be considered one operation, and operations that are not separated by three months shall be deemed to have been performed during "a continuous period of disability."

II. UNLISTED PROCEDURES

In addition to the procedures listed in this Schedule, amounts shall be payable for cutting operations performed in a legally constituted and operated hospital while the patient is confined, other than as

"out-patient." The maximum amounts for such procedures shall be determined in amounts consistent with those listed.

General Surgery

Infections and Traumata

Abscess incision and drainage, furuncles excepted	$ 5.00
Deep cervical abscess	25.00
Carbuncle	25.00
Ulcer, surface excision	10.00
Tendon, repair, one primary	25.00
each additional	10.00
maximum	100.00
Septic finger (tendon sheath involvement)	15.00
Septic hand (tendon sheath and compartments)	75.00
Lacerations, extensive, including debridement	25.00

Cysts

Cyst, sebaceous, removal	$ 10.00
Pilonidal cyst or sinus	50.00
Thyroglossal cyst, removal	100.00
Bronchial cyst, removal	100.00

Tumors

Tumors, benign external, removal	$ 10.00
Tumors, benign, removal deep	25.00
Epulis, removal	15.00
Parotid tumor, removal	75.00
Epithiolioma of face, surgical removal	25.00
Cancer of tongue, (resection or removal)	100.00
Same with neck dissection	150.00
Cancer of lip (local operation)	35.00
Same with neck dissection	125.00

Biopsy

Biopsy, superficial	$ 5.00
Biopsy, bone or bone marrow	15.00
Biopsy, needle aspiration	5.00

Glands

Glands, superficial, removal	$ 10.00
Dissection glands of neck, deep chain	100.00
Radical axilla or groin	100.00

Thyroid

Thyroidectomy, subtotal	$125.00
Ligation preliminary to thyroidectomy	25.00
Thyroidectomy, two-stage, subtotal (with or without ligation) complete procedure	150.00
Parathyroidectomy	150.00

Breasts

Breast abscess, drainage	$ 25.00
Breast cyst or abscess, aspiration	10.00
Breast, tumor, benign, removal	35.00
Breast, radical removal, including axillary dissection	125.00
Breast, simple removal	75.00

Miscellaneous

Ligation, saphenous vein, low, including retrograde injection, if done	$ 25.00
Ligation, saphenous vein, high, (and combined) including retrograde injection, if done	40.00
Extensive varicose veins, one leg	50.00
(Multiple ligations on same or successive days)	
Same, bilateral	100.00
Toe nail, ingrown, removal radical	20.00
Stone, submaxillary or parotid duct	25.00
Removal of submaxillary salivary gland	50.00
Injection, varicose veins, complete procedure	25.00

Endoscopy

(When preliminary and related to surgical service only)

Bronchoscopy, diagnostic, preceding surgery	$ 25.00
operative	50.00
Cystoscopy	
Observation (preceding surgery)	15.00
Ureteral catheterization	20.00
Operative	35.00
Gastroscopy	25.00
Laryngoscopy	
Diagnostic (by laryngoscope)	10.00
Operative	25.00
Peritoneoscopy	25.00
Sigmoidoscopy and biopsy	10.00
Esophagoscopy	25.00

Special Surgery

Thoracic Surgery

Pneumolysis	$ 75.00
Pleura, paracentesis	10.00
Empyema, closed drainage	25.00
Empyema, rib section	75.00
Phrenic nerve, crushing	25.00
Thoracoplasty (First stage or partial)	75.00
(Complete)	150.00
Lobectomy	150.00
Aneurysmorraphy	150.00
Induction of artificial pneumothorax	25.00
Refills	5.00

Abdominal Surgery

Abdomen, paracentesis	$ 10.00
Herniotomy, single inguinal, femoral or umbilical	100.00
Herniotomy, bilateral inguinal or femoral	125.00
Herniotomy, hiatus or diaphragmatic	150.00
Herniotomy, ventral or incisional	100.00
Esophageal diverticulum	125.00
Gastrotomy or gastrostomy	100.00
Gastrectomy	150.00
Gastro-enterostomy	125.00
Peptic ulcer, perforated, closure	100.00
Peptic ulcer, subtotal gastrectomy	150.00
Pyloric stenosis (Rammstedt's in infant)	100.00
Intestines, anastomosis	125.00
Intestines, (small) resection	125.00
Adhesions, freeing of	100.00
Laparotomy	75.00
Colon, resection	150.00
Colostomy	75.00
Appendectomy	100.00
Diverticulum, intestinal	100.00
Appendiceal abscess, drainage	100.00
Subdiaphragmatic abscess	100.00
Cholecystectomy	125.00

liary surgical drainage—common duct
and cholecystectomy 150.00
ommon duct, resection or reconstruction 150.00
holecystostomy 100.00
holecystoduodenostomy 125.00
ncreas, drainage 100.00
plenectomy 150.00

Proctology

emorrhoids, injection treatment, complete procedure ..... $ 25.00
emorrhoid, thrombosis, incision 5.00
emorrhoids, internal 35.00
emorrhoidectomy 35.00
stulectomy, single, excision of tract 50.00
multiple, excision of tract 75.00
ssurectomy 10.00
olypectomy 25.00
bscess, ischiorectal or perirectal drainage 20.00
rcinoma of rectum, resection 150.00
rianal abscess, drainage 5.00
olapsed rectum, repair 100.00

Urology

rcumcision, infant not requiring anesthesia ..... $ 5.00
rcumcision, excepting the above 15.00
rethrotomy, external, except meatotomy 50.00
rethrotomy, internal 50.00
ostatic abscess 35.00
ostatectomy, perineal 125.00
ostatectomy, suprapubic—one stage including vasectomy 125.00
ostatectomy, suprapubic—two stage including vasectomy 150.00
ostatectomy, transurethral 100.00
nch operation with suprapubic drainage 100.00
rincoplasty with urethral repair 75.00
ydrocele, radical operation 50.00
tholapaxy 50.00
idiidymectomy 50.00
asectomy (when not preliminary to prostatectomy) 25.00
esiculectomy 100.00
aricocelectomy 50.00
rchidopexy—one stage 75.00
two stage 125.00
rchidectomy simple 50.00
With gland dissection 100.00
ystotomy or Cystostomy 75.00
ystostomy with fulguration 100.00
ystectomy 150.00
reter transplantation, single 100.00
bilateral 150.00
adder tumor, diverticula, etc. (resection)—
open operation 125.00
retero-lithotomy 100.00
ephrotomy 125.00
ephrostomy 125.00
ephrectomy 125.00
ephropexy 100.00
elotomy 100.00
astic on pelvis and ureter 125.00
Heminephrectomy 125.00
Excision and suture of urinary fistula (suprapubic) .. 50.00
(vaginal) 100.00
Penis amputation 75.00
Same with groin dissection 150.00
Plastic hypo—and epispadias 125.00
Meatotomy 5.00
Caruncle excision 15.00
Caruncle fulguration 15.00

NEUROSURGERY

Skull

Simple fracture, non-operable, with brain injury ..... $ 35.00
Depressed 75.00
Compound 150.00
Brain tumors 150.00

Brain Injuries; operable

Extradural hematoma $150.00
Subdural hematoma 150.00
Exploratory trephination
One side 50.00
Two sides 75.00
Intracortical clot 150.00
Arterio-venous fistula, intracranial 150.00

Spinal Cord

Section of anterior or posterior roots $150.00
Decompressive laminectomy 150.00
Removal of or exploration for an extruded nucleus, pulposus or ruptured intervertebral disc 150.00

Peripheral Nerve

Suture, decompression, or transplantation of single nerve ..... $ 25.00
Each additional 10.00
Maximum 100.00
Pneumonenchephalogram 25.00
Ventriculogram 35.00
Spinal cord tumors 150.00
Operation for pain associated with malignancy or similar untreatable disease requiring intraspinal nerve sections or cordotomy 150.00

Miscellaneous

Section of sensory root for 5th nerve neuralgia 150.00
Section of vestibular nerve for Meniere's disease or aural vertigo 150.00
Operation for Scalenus anticus syndrome 50.00
Craniotomy for brain abscess 150.00
Craniotomy for conditions not listed herewith 150.00
Bilateral orbital decompression 150.00
Choroidectomy for hydrocephalus 150.00
Excision of meningocele 75.00
Lumbar puncture, with fracture or operative work, (diagnostic excluded) 5.00

Sympathetic System

Unilateral lumbar sympathectomy $100.00
Bilateral lumbar sympathectomy 150.00
Resection of pre-sacral plexus 150.00
Bilateral, thoraco lumbar sympathectomy 150.00

Obstetrics

Pregnancy, delivery	$ 50.00
(Does not cover prenatal and postnatal home and office care.)	
Miscarriage (curettage)	25.00
Caesarean section, vaginal	100.00
Caesarean section, abdominal	100.00
Pregnancy, ectopic	100.00

Gynecology

Bartholin's gland, incision	$ 5.00
Bartholin's gland, excision	25.00
Labial tumors and cysts, removal	20.00
Atresia of vagina, plastic	50.00
Fistula, recto-vaginal	100.00
Fistula, vesico-vaginal	100.00
Cul-de-sac, drainage	35.00
Cauterization or conization of cervix	10.00
Dilatation with or without curettage or cauterization	25.00
Uterine polyp removal with dilatation and curettage	25.00
Cervical polyp removal	5.00
Trachelorrhaphy	35.00
Cervix amputation	50.00
Oophorectomy or resection of ovaries	100.00
Hysterectomy	150.00
Myomectomy	100.00
Uterine flexions, etc., correction, (plus surgery of tubes and ovaries)	100.00
Same with vaginal plastic repair	125.00
Salpingectomy	100.00
Salpingoophorectomy	100.00
Cystocele	50.00
Rectocele	50.00
Combined cystocele and rectocele	75.00
Prolapse operations (interposition, Manchester)	100.00
Vulvectomy	75.00
With groin dissection	150.00

Ophthalmology

Foregin body removal, within anterior or posterior chamber	$100.00
Cornea, parecentesis	20.00
Conjunctival suture	15.00
Conjunctival flap for corneal ulcer, etc.	25.00
Chalazion, excision, single	10.00
multiple	25.00
Lachrymal sac, removal	50.00
Entropion or ectropion, Ziegler's puncture	30.00
Entropion or ectropion, plastic operation	50.00
Entropion or ectropion, plastic operation grafts or flaps	75.00
Symblepharon, release	30.00
Pterygium	25.00
Corneal ulcer, cauterization	5.00
Corneal ulcer, deliminating keratotomy	25.00
Tarsorrhaphy, orbicularis paralysis	30.00
Ptosis, (single)	50.00
Strabismus, one or more muscles	75.00
Cataract, needling	40.00
Cataract, removal	100.00
Iridectomy	50.00
Glaucoma, filtration operation	100.00
Enucleation or evisceration	50.00
Same and implantation	75.00
Tumor, exenteration of orbit	100.00
Dacryocystorhinostomy	100.00
Detached retina	125.00

Otology

Aural polyp	$ 10.00
Paracentesis tympani	10.00
Mastoidectomy, acute single	100.00
Mastoidectomy, acute bilateral	125.00
Mastoidectomy, radical single	150.00
Fenestration for otosclerosis	150.00

Nose and Throat

Nasal polyps, removal	10.00
Antrum, Caldwell-Luc	50.00
Ethmoidectomy	35.00
Frontal sinus, radical	100.00
Turbinectomy	10.00
Submucous resection	50.00
Palatorrhaphy	100.00
Tonsillectomy and adenoidectomy	
Under 15	25.00
Over 15	35.00
Laryngectomy	150.00
Tracheotomy	50.00
Malignant disease, accessory sinuses (radical operation)—One sinus	100.00
Multiple	150.00
Malignant disease, tonsil and pharynx (radical operation)	100.00
Antrum puncture and irrigation	5.00
Antrum window	50.00

Orthopedic

Spinal fusion	150.00
Cartilage of condyle of femur, removal of	75.00
Bone plate, removal of	25.00
Talipes	50.00
Semilunar cartilage, removal from joint	75.00
Tenotomy, simple, open	25.00
closed	15.00
Claw foot, except bone surgery—see foot stabilization	50.00
Coccyx, excision of	25.00
Arthrotomy, any major joint	75.00
Hallux valgus, single radical operation	50.00
exostectomy	25.00
Osteomyelitis, sequestrum removal	25.00
Hallux valgus, bilateral radical operation for	75.00
Foot stabilization	150.00
Hammer toe, operation for	35.00
Arthrodesis of knee, hip, shoulder or elbow	150.00
Torticollis, operation for	75.00
Arthroplasty, any major joint	150.00
Hip joint, resection	150.00
Any other major joint, resection	100.00
Any joint, fingers or toes, resection	25.00

Amputations

Shoulder, disarticulation	$125.00
Upper arm	50.00
Forearm	50.00
Hand	50.00
Finger, single	15.00
Each additional	10.00
Hip	125.00
Thigh	75.00
Knee	75.00
Leg	75.00
Toe	15.00
Each additional	10.00
Foot	50.00
Elbow	75.00
Scapulothoracic amputation	150.00

Dislocations, Closed

Carpal bone, one	$ 25.00
Each additional	10.00
Clavicle	25.00
Elbow	25.00
Finger, one	5.00
Each additional	5.00
Hip	35.00
Knee	35.00
Mandible	10.00
Metacarpal bone, one	15.00
Each additional	5.00
Metatarsal bone, one	15.00
Each additional	5.00
Patella	15.00
Rib	10.00
Shoulder	25.00
Tarsal bone, one	25.00
Each additional	10.00
Thumb	10.00
Toe, one	5.00
Each additional	5.00
Vertebra, one or more	100.00

Simple Fractures, Closed

Lower jaw	$ 25.00
Carpal bone, one	25.00
Each additional	10.00
Clavicle	25.00
Coccyx	10.00
Femur	75.00
Tibia or fibula or both	50.00
Potts' or Cotton's fracture	75.00
Finger, one	10.00
Each additional	5.00
Humerus	50.00
Metacarpal bone, one	15.00
Each additional	10.00
Metatarsal bone, one	15.00
Each additional	10.00
Patella, closed	25.00
Nasal bone or bones, reduction	25.00
Pelvis	75.00
Radius or ulna, or both	25.00
Rib, one or more	10.00
Sacrum	35.00
Scapula	25.00
Skull	35.00
Sternum	25.00
Tarsal bone, one (exclude os calcis and astragalus)	25.00
Each additional	10.00
Toe, one	10.00
Each additional	5.00
Vertebra, one or more	100.00
Os calcis or astragalus, or both	50.00

Open Reductions and Compound Fractures

For compound fractures the maximum amount will be one and one-half times, and for fractures or dislocations requiring an open operation will be twice the amount shown for the corresponding simple fractures or dislocations, but in no case more than $150.00.

Additional Benefits for Anesthesia and Transfusions

Anesthesia

When administered by a licensed doctor of medicine other than the operating surgeons and the insured is billed directly by such physician anesthetist, the amount opposite the fee range listed below shall be paid:

When fee for surgical procedure is	the indemnity for anesthesia shall be
Under $50.00 (for other than tonsillectomy)	$ 10.00
$50.00 to $99.00	15.00
$100.00 to $150.00	20.00
Tonsillectomy*	8.00

Transfusions of Blood or Plasma

When administered by a licensed doctor of medicine and during the course of any operative procedure for which indemnity is provided under this policy	$ 5.00
Payment for transfusions shall be limited to two (2) during the course of any operative procedure.	

*Under 14 years of age.

SCHEDULE C

Participating Physician of the Connecticut State Medical Society

I hereby subscribe as a participating physician under the plan sponsored by the Connecticut State Medical Society for voluntary prepaid surgical and obstetrical insurance, as accepted and approved by the Connecticut State Medical Society.

In consideration of my being listed as such "Participating Physician," I hereby agree that my charges for the services included in the Master Schedule of Surgical Indemnities, as approved by the Connecticut State Medical Society under such plan, and rendered to the insured or his dependents, shall not exceed the amount specified therein, provided the insured is (a) an individual whose total income does not exceed $2,000 per year and whose total aggregate family incomes do not exceed $3,000 per year, or (b) an individual with dependents whose total aggregate income does not exceed $3,000 per year at the time of disabiilty.

I understand that persons whose incomes exceed such limits shall have such indemnity applied towards my total

bill with such persons liable for any additional fee charged by me.

I understand that nothing in this agreement is intended to effect the relationship between the physician and his patient nor to restrict the physician in the exercise of his right to decline to treat any patient for appropriate professional reasons.

I further agree to abide by the rulings of the Society's Committee on Prepaid Medical Insurance which will function under this program for the expressed purpose of facilitating any administrative problems that may arise.

I understand that I may wtihdraw as a Participating Physician upon giving reasonable notice to the Connecticut State Medical Society prior to publication of a new list of Participating Physicians.

.....M.D.

Address:

Date:

SCHEDULE D

DIRECTION TO PAY AND PHYSICIAN'S AGREEMENT

(Connecticut State Medical Society Plan for Prepaid Surgical Service)

Date.....

IN CONSIDERATION of the Physician's Agreement hereto annexed, I hereby authorize and direct the.....

.....

..... Company

to pay to .....

.....

(Name) (Address)

and others designated by him, the benefits to which I may be or become entitled under the Connecticut State Medical Society Plan for Prepaid Surgical Service issued to.....

.....

(Name of Employer, Organization, or Other Insured)

by reason of service performed or to be performed, I am within the Eligible Income Group, as defined below.

.....

(Signature of Insured)

IN CONSIDERATION of the direction to pay hereto annexed, I hereby agree with .....

(Insured)

that my charges for the services which are included in the Schedule of Surgical Expense Benefits (Connecticut State Medical Society Plan for Prepaid Surgical Service), rendered to said insured whose signature appears above, shall not exceed the amount specified therein, provided that said insured is within the Eligible Income Group (an individual whose total income does not exceed $2,000 per year and whose total aggregate family incomes do not exceed $3,000 per year, or an individual with dependents whose total aggregate income does not exceed $3,000 per year at the time of disability).

.....

(Signature of Physician)

INTERIM REPORT OF THE COMMITTEE ON TUMOR STUDY

Among the duties of the tumor committee is the nomination of the members of the medical advisory committee of the Connecticut Cancer Society. The nominations were made (and subsequently accepted by the Cancer Society) as follows:

Dr. Alfred L. Burgdorf, Hartford, *Chairman*
Dr. Wilmar M. Allen, Hartford
Dr. Howard S. Colwell, New Haven
Dr. William U. Gardner, New Haven
Dr. Joseph I. Linde, New Haven
Dr. Edward J. Ottenheimer, Willimantic
Dr. Donald B. Wells, Hartford

The chairmen of the subcommittees of the committee on tumor study were elected as follows: Scientific, Dr. Kendall; Medical Education, Dr. Ottenheimer; Institutional Care, Dr. McLellan; Public Relations, Dr. Roberts; Publications, Dr. Thoms. This committee acts as the executive committee.

During the phase of organization it was noted that the committee had no definite rules of procedure. The executive committee was designated by the committee as a whole to propose such rules which are at present under consideration.

Realizing the value of the large and unique body of statistical information concerning cancer in a large population that has become available in the Division of Cancer Research of the Connecticut State Department of Health, contact was established with the Division through the scientific committee. It was strongly felt that this information should be made publicly available, under medical supervision representative of the physicians of the State. In several meetings with the cancer group, cordial cooperation was enlisted in bringing to fulfillment a plan suggested by the scientific committee. This plan encompasses the presentation of the fundamental statistical data concerning the most important types of carcinoma. This will include only the data already coded in the cards and will leave for subsequent study by qualified physicians the clinical minutiae. It is planned to publish these analyses in a uniform manner in the CONNECTICUT STATE MEDICAL JOURNAL, with the ultimate plan of publishing a monograph under the joint auspices of the Division of Cancer Study and tumor study committee.

The tumor study committee considered, approved, and referred to the medical advisory committee of the Connecticut State cancer committee, a plan submitted by the Connecticut State Association of Pathologists for establishing cytological diagnosis centers in the tumor clinics of the New Haven and Hartford hospitals. The plan was suggested in order to provide service in diagnosis of vaginal smears, sputum smears, etc., under adequate scientific supervision, and to train technicians who may later be used in tumor clinics throughout the State. Ths plan awaits further consideration by the medical advisory committee upon application of the two tumor clinics involved. This method of training would avoid the practice of a probably valuable technique by unqualified persons who might throw it into disrepute.

Respectfully submitted,
Averill A. Liebow, M.D., Chairman

PROGRESS REPORT OF THE COMMITTEE TO STUDY WORKMEN'S COMPENSATION LAWS

To the House of Delegates:

The committee to study the Workmen's Compensation Laws have had four meetings. The first meeting was a get together organization meeting. The meeting was held at the offices of the State Medical Society in New Haven with a full attendance.

The second meeting was held August 19, 1947 at the offices of the State Medical Society. One member was absent. Representatives of Connecticut Labor were interviewed. Secretary Joseph Rourke represented the Connecticut Federation of Labor and Mr. H. Senior of Waterbury represented the Connecticut C.I.O.

The question of freedom of choice of physicians in compensation cases was discussed. Both labor representatives that were interviewed strongly recommended that the State Medical Society support a change in the law to provide for free choice of physicians.

The representatives of labor made the following statement:

"We support the principle of the general field of medical care, and only ask that the same principle be specifically applied in this particular field of medical care."

The third meeting was held at the Graduate Club in New Haven on October 25, 1947. Dr. David Kaliski, director, Workmen's Compensation Bureau, Medical Society of the State of New York and Dr. James J. Donohue of Norwich, Connecticut ex-compensation commissioner were present.

Dr. Kaliski explained the structure and workings of the compensation law of New York. He expressed himself in favor of the New York law over the Connecticut law.

Dr. James J. Donohue of Norwich was compensation commissioner of the Second Congressional District from the time the law first went into effect in this State in 1913, continuously until 1942, with the exception of one term. He served five terms, a period of twenty five years.

In the early period of his terms he strongly favored the present law.

About twenty-five years ago he read a paper in San Francisco in support of his belief at that time that the employer and insurance carrier should choose the physician.

In his later terms he changed his ideas and he came to believe just as strongly that the freedom of choice by the employee rather than by the employer or the insurance carrier was much better in the interests of all parties concerned.

The fourth meeting was held at the Graduate Club in New Haven, November 20, 1947. At the suggestion of a member of our committee, Charles F. Yeager, M.D., of Bridgeport, industrial surgeon for the DuPont Co., Eugene Meschter, M.D., industrial surgeon for the Yale & Towne Co., Stamford, and Martin Hall, M.D., industrial surgeon for the New Departure Co. of Bristol, were invited to attend this meeting. Dr. Hall did not appear.

The industrial surgeons expressed their satisfaction with the present law.

Respectfully submitted,
Thomas Soltz, M.D., Chairman

REPORT OF COMMITTEE ON MILITARY HISTORY

To the House of Delegates:

The Committee has held two meetings and has had correspondence by mail since the last meeting of the House of Delegates. The biographical sketches have now been completed from all members who returned their service questionnaires and will probably be published in the JOURNAL during 1948 in three or four installments. The details of all this work have been handled in the secretary's office. Plans are underway for appointing an editor whose job it will be to go over all the material that has been turned in, organize it and write the narrative account of the participation of Connecticut physicians in the war. It is also hoped that this material will be published in the JOURNAL and then in a volume similar to the "Heritage of Connecticut Medicine," which was published at the time of the sesquicentennial. Progress has necessarily been slow, but we trust that its results will appear in 1948.

Ralph L. Gilman, M.D., Chairman

REPORT OF ADVISORY COMMITTEE TO STATE HEALTH DEPARTMENT ON PSYCHIATRIC CLINICS

In the 1945 General Assembly, the Department of Health requested a sum of $200,000 to initiate a program of psychiatric service in general hospitals. A sum of $50,000 for each of two years was granted at that time. After the legislature had appropriated the funds for this purpose, the Commissioner of Health requested the State Medical Society to nominate three general physicians and three psychiatrists to an advisory committee and he asked the Connecticut Hospital Association to nominate three hospital administrators. The advisory committee so nominated was appointed by the Commissioner of Health. On November 5, 1945 Doctor Wilmar M. Allen resigned from the committee and I was appointed to his place and elected chairman.

The committee instructed Doctor James M. Cunningham, director of the Bureau of Mental Hygiene, to circularize all general hospitals in the State, asking them to submit any plans which they might have in connection with the development of psychiatric service. Replies were received from 15 hospitals, indicating interest in developing such a program provided financial assistance could be obtained.

The committee subsequently drafted a set of policies to govern, under which the State Department of Health might grant funds to the hospitals for aid in developing psychiatric service. After some revisions these recommendations were approved by the State Public Health Council at its meeting in January 1946. A copy of these policies is enclosed.

Applications from 5 hospitals were subsequently received: namely, New Haven, Waterbury, Stamford, Greenwich and St. Francis. The Public Health Council set a maximum figure of $9,775 to be allotted to any one hospital in view of the total amount of funds available.

There developed some delay in obtaining adequate personnel to initiate the program. Dates of starting were as follows:

Greenwich Hospital, April, 1946
Waterbury Hospital, July, 1946
New Haven Hospital, July, 1946
Stamford Hospital, September, 1946
St. Francis Hospital, January 1, 1947

During the first year of the biennium 1945-1947, a small amount of the $50,000 grant was actually expended. In the second year of the biennium 1946-1947, the majority of the $50,000 was expended. The State Department of Health in its budget request of the 1947 General Assembly put in an item of $200,000 for the further development of psychiatric service in general hospitals. The legislature did not approve this request but continued the appropriation of $50,000 which had been previously granted. By July 1 of this year all five hospitals to whom funds had been granted were working with staffs now secured. All reapplied for continuation of the grants and these reapplications were approved. The State Health Department, not having additional funds with which to develop service in other hospitals, therefore, has not sought to interest or develop additional new work at this time since the funds have been allotted to the five hospitals mentioned above.

Since the hospitals are now operating under the policies established, and it has been impossible to expand the program further, there has been no need of further meetings of the committee during the past year. However, on the chance that some change in the program may develop or more funds may become available, I should advise that this committee be continued at least for one year.

Sincerely yours,
James C. Fox, Jr., M.D., Chairman

REPORT OF THE COMMITTEE ON COOPERATION WITH YALE SCHOOL OF MEDICINE

Mr. President and Gentlemen of the House of Delegates:

The Committee on Cooperation with Yale University Medical School has had two meetings. The first on October 6 and the second on November 10. Both meetings were well attended and questions of mutual interest to the Society and the medical school were freely discussed and I believe to the advantage of both parties.

As a result of these meetings two major plans are in progress which we believe will be of great benefit to the Connecticut State Medical Society.

Postgraduate education was the first matter discussed. At our request the medical school is planning postgraduate courses of very high standard and very largely for the benefit of the members of this society. These courses will be operated by a postgraduate committee of the medical school with representatives of the Society on the committee. A full time director of postgraduate education is to be engaged for this work. Some of the courses planned are for industrial physicians, health officers and practitioners. The society intends to send out questionnaires to determine the type and scope of postgraduate education desired by the members. Your committee feels that the chief purpose of the Connecticut State Medical Society is to provide and sponsor graduate education for its members. To organize and get this postgraduate school in operation will require funds. The society must do its part in this undertaking. Your committee recommends that the sum of ten thousand dollars ($10,000) be appropriated over a period of two years for this purpose. The medical school will appropriate the same amount. This money will be used to begin this operation and after that the graduate school will carry the burden alone.

The second major objective is the operation, at the medical school, of a very high grade diagnostic clinic comparable to or better than some of the larger clinics in nearby states. Only patients referred by physicians will be accepted. A diagnosis only to be made and the patient returned to his physician with a complete report and advice. Your committee feels that in this way many patients getting to clinics without the state will be maintained within our own borders. The physician will retain direct control of his patient after the diagnostic problem has been solved. The diagnostic clinic committee of the medical school is now working on this program.

The medical school was started by the Connecticut State Medical Society over one hundred years ago. The school authorities seek closer cooperation with the Connecticut State Medical Society. We seek their continued cooperation. Your committee is pleased to report the very cordial relations existing between the medical school and this society at the present time.

Respectfully submitted,
T. P. Murdock, M.D.

The recommendation of the above committee that $10,000 be appropriated over a period of two years for the purpose of providing postgraduate education for the members of the Society was approved by the House of Delegates.

The House of Delegates adjourned at 5:30 P. M.

New British Journal of Anesthesia

Anaesthesia: Journal of the Association of Anaesthetists of Great Britain & Ireland, a quarterly publication, has just completed the first year of its existence. The first issue of Volume One contains interesting contributions from such individuals as Sir Alfred Webb Johnson, C. Langton Hewer, F. W. Featherstone, A. D. Marston, F. Barnett Mallinson, A. R. Hunter, John Beard and Noel Gillespie. Subsequent issues throughout the year have been equally interesting and informative. This periodical deserves a warm welcome in this country. With the increased interest being shown in recent years and the increasing number of physicians specializing in the field of anesthesiology, it arrives on fertile soil at an appropriate time.

Not only will anesthetists find the periodical of interest but surgeons and other specialists might well become intrigued with the problems of British anesthetists where "the law makes the anesthetist answerable for the life of the unconscious patient."

COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

A meeting of the Council of the New England State Medical Societies was held at the Copley Plaza Hotel, Boston, Massachusetts, on Tuesday, October 28, 1947. The following were in attendance:

Connecticut: Cole B. Gibson, M.D., Joseph H. Howard, M.D., Grace Mooney, PH.D.

Maine: Frederick R. Carter, M.D., Stephen A. Cobb, M.D., Mayo W. Payson.

Massachusetts: Norman A. Welch, M.D., Archibald J. Douglas, M.D., Gerald Hoeffel, M.D.

New Hampshire: Howard Sawyer, M.D., Ralph W. Tuttle, M.D.

Rhode Island: Arthur H. Ruggles, M.D., H. Lorenzo Waldy, M.D., John E. Farrell.

Vermont: W. W. Angell, M.D., John W. Brownlee.

Also present as guests were Doctors J. F. Conlin, Robert Fleming, Joseph Garland, Harold G. Gallupe and Mr. Robert Boyd, all of Boston.

The meeting was called to order by President Arthur H. Ruggles.

Mr. John E. Farrell presented his report as Executive Secretary-Treasurer. In this report he concluded by calling attention to the formation of a conference of the officers of the New England States dental societies, and he suggested the possibility that the Council might extend an invitation to this dental group to meet with it at some future date. It was moved that a joint meeting be held with the New England State dental societies in the spring. The motion was seconded and adopted.

Dr. Ruggles asked Dr. Howard to report on the meeting of the National Physicians Committee held in Chicago in September.

Mr. Farrell reported on the radio program "Doctor's Orders" which was started in Providence with the co-sponsorship of the Rhode Island Medical Society in September, 1944, and which has been presented weekly ever since and has been received enthusiastically according to all reports. He explained the workings of the program whereby a dramatization by professional actors utilizing scripts prepared by skilled writers is climaxed by a three and a half minute interview with a doctor speaking from the Rhode Island Medical Society.

Mr. Farrell reported that this program under the direction of Radio Productions in Providence is now to be carried over the Yankee network—the Mutual System—in New England. This makes it a public relations program for the New England medical societies and will bring an excellent educational radio health program into every state.

Mr. Farrell explained that the program would be set up so that doctors in local communities could participate in the interview which concludes the program each week, thus allowing for district medical societies to localize the program to their own advantage.

There was brief discussion of the radio program and Dr. John Conlin, health education director of the Massachusetts Medical Society, reported that his society was enthusiastic following the first broadcast held on Sunday, October 26. Dr. Conlin stated that he believed the program offered an unusual opportunity for the medical societies to do a worthwhile job in radio medical education.

Mr. Brownlee inquired regarding the sponsorship and stated he was under the impression that a local sponsor had participated in the program over one of the Vermont stations. Mr. Farrell stated he would investigate this matter and report immediately to the Vermont Medical Association.

Miss Mooney stated that Dr. Barker had asked her to convey the suggestion that the Council of the New England Medical Societies might well be the body to which questions might be referred regarding the radio program "Doctor's Orders."

The discussion was concluded with the motion that the Council of the New England State Medical Societies go on record as approving the radio program "Doctor's Orders" and that the delegates be asked to convey this information back to their respective state societies. The motion was seconded and adopted.

Reporting for Maine, Dr. Stephen A. Cobb, president of the Society, said that for the first time in its history the Association was having a fall meeting of the House of Delegates on November 9 and 10 at which time there would also be held a clinical session at the Central Maine General Hospital and at St. Mary's General Hospital.

Dr. Cobb concluded his remarks by reporting that the Society is faced with keen competition from the osteopathic physicians who have made deep inroads in many areas. He stated that the Association is endeavoring to find a solution whereby physicians may be admitted to practice in the state by reciprocity without going before the board of medical examiners for complete written licensure examination.

Dr. Tuttle, reporting for New Hampshire, said that both the Blue Cross and the Blue Shield, the hospitalization and the surgical-medical plans in New Hampshire are going strong with increasing enrollment and good actuarial experience.

Mr. Brownlee, executive secretary of the Vermont Medical Society, reported that the state health council, instituted by the Society, had attained excellent progress with twenty-eight state organizations now represented. The plan now underway is to filter down to the county or trading area basis in order to bring in wider representation of local groups in health planning.

He reported that the Society is still working on the Surgical Insurance enrollment in the New Hampshire-Vermont physicians program plan but that difficultiy had been encountered by reason of the requirement that groups be enrolled. He stated that the central organization had taken some of the sizeable employee groups such as the railroad employees, etc.. but had been slow to seek community enrollment through the farm bureau or the Granges. In his opinion the latter groups offered a basis for sizeable enrollment and it would appear that in Vermont the signing up of such groups would have to be secured for the success of the plan.

Dr. Norman Welch reported on Massachusetts' experi-

ence with the Blue Shield, the surgical-medical program, stating that it now had 600,000 subscribers, and was the second ranking plan in the country. He stated it started with surgical and obstetrical coverage but in June of this year had added medical service in the hospital and surgery in the home and office. He stated it now had a reserve of $1,000,000 and when the medical program was added it was anticipated that there would be a 50 per cent claim but unfortunately that has been running closer to a 100 per cent until the present time.

He stated that the medical program now offers $5 for the first day, then $3 for each of the succeeding twenty-one days maximum. He stated that the plan had tried to eliminate expensive claims for chronic illness. The expense of administration has been reduced to a minimum and is now running from 8 to 9 per cent of the total income. In answer to an inquiry Dr. Welch reported that the Blue Shield is run as an individual plan with no connection with any insurance companies as it was felt by the Massachusetts Medical Society that it would be better if it ran the program itself as a gesture of its interest in serving the public. He also reported that should the reserve fund be lowered at some future date it would necessarily follow that the fees to physicians would have to be pro-rated. He reported that an excess of 6,000 participating physicians, out of a total of 7,500 physicians in the state, had been enrolled.

In answer to a question from a member of the Council Dr. Welch reported that the executive committee of the Medical Society elects the directors of the Blue Shield, and the directors form a committee to act as the professional service committee. Similar professional service committees have been established in the district societies and they in turn can report grievances to the state committee.

In answer to an inquiry from Mr. Brownlee regarding relations with the Blue Cross, Dr. Welch answered that the Blue Cross merely merchandises the society's program and that the Blue Shield has its own employees although it does employ on a part time basis some of the Blue Cross workers. Both agencies utilize the same building.

Dr. Howard reported that Connecticut had initiated a program for the care of the chronically ill and that he had been appointed as a member of the Governor's commission to handle this program. He stated that the State had been asked to appropriate $1,000,000 and that actually $900,000 had been allocated for the chronically ill. In view of the fact that the state now has a sales tax from which sizeable income is accruing he expressed the opinion that a large part of this money may go towards revamping the state institutions.

As one of the first major steps in the approach to the chronically ill care, Dr. Howard reported that $600,000 of the state appropriation has been allocated for the operation of the Rocky Hill Hospital, a 600 bed insttiution, at which efforts will be made to try and rehabilitate some of the chronically ill. A joint commission, the Rocky Hill Hospital group and a state commission for the chronically ill, will operate the hospital which will be opened about January 1. At the present time the detail work is being completed and the acquisition of a medical, nursing and technical staff is being carried out.

Dr. Gibson moved that the Council hold a public relations conference at which there shall be state, county and district medical society representation. The motion was unanimously adopted.

It was moved by Dr. Welch that Dr. Conlin, Mr. Farrell and Mr. James Burch of the Connecticut Medical Society be named as a committee to proceed with arrangements for such a conference and that it consider the advisability of holding it in Boston on Sunday, March 7, 1948. The motion was seconded and adopted.

"THE ANTI-VIVISECTION SITUATION IN NEW ENGLAND"

Dr. John F. Conlin, director of medical information of the Massachusetts Medical Society, and also New England representative of the National Society for Medical Research, addressed the Council on the problems of combating anti-vivisection legislation and activities in this area.

Dr. Conlin cited experience in Massachusetts where such legislation was defeated by a single vote a year ago. He stated that Massachusetts was particularly vulnerable to these attacks by reason of the fact that it has three medical schools in Boston, one school of public health, and in addition, has three Hearst newspapers leading an attack on vivisection.

He stated that the problem was a major one and was not to be dismissed lightly, even though some of the states do not at present face any active work on the part of the anti-vivisectionists. He reported that the group has much money: for example, two Chicago women recently left $2,000,000 and another woman has left a half million dollars, which is to provide for the introduction of legislation in each state for many years to come.

He said that he would estimate that not more than 5 to 10 per cent of the general public knows what the problem is all about. The New England Anti-Vivisection Society has 5,000 members but he reported that only a hundred of this group are active. This minority puts on campaigns and attempts to "bully" groups to support its cause. A flood of letters is turned loose on editors of newspapers thus making some of them reluctant to oppose the activities of the anti-vivisectionists.

Dr. Conlin told of the work of the National Medical Research Society which is now campaigning to educate the 80 per cent of the people who know nothing of the program of the anti-vivisectionists and who are somewhat misled by the emotional appeal of this group. He expressed the belief that if each state had an organization it could match these proponents at their own game and could defeat their activities.

He gave an interesting summary of arguments that can be used to turn the anti-vivisectionists' arguments against them and to expose the fallacies of many of their claims. He stated that his organization has compiled this material and it is ready to show any group how to win popular support. He said that in Massachusetts contacts had been made with the legislators through the doctors who render medical service to the individual members of the legislature, and this year the Society will present a bill which would authorize the use of dogs from public pounds for experimental work in medical laboratories. He agreed to send copies of the material prepared by the National Society

for Medical Research to all members of the Council of the New England State Medical Societies.

His topic was discussed briefly by several members of the Council and Dr. Arthur H. Ruggles expressed the thanks of the group for the very instructive and educational presentation given.

"AN OUT-PATIENT APPROACH TO THE TREATMENT OF ALCOHOLISM"

Dr. Robert Fleming, chief of the Out-Patient Clinic for Alcoholism at the Peter Bent Brigham Hospital, addressed the Council on the above topic. He gave a resume of cases treated at his clinic and presented some interesting observations regarding the operation and the success of the clinic, expressing the belief that similar clinics might well be started in any general hospital. A complete summary of Dr. Fleming's remarks is attached to and made part of the minutes of this meeting.

THE DOCTOR'S OFFICE

George Crawford, M.D., announces the opening of an office for the practice of surgery on the Middlesex Turnpike, Essex.

Anthony D. Intriere, M.D., announces the opening of an office for the general practice of medicine at 18 Field Point Road, Greenwich.

Abraham I. Levine, M.D., announces the opening of an office for the general practice of medicine at 3 Strickland Road, Cos Cob.

Mario J. Mancinelli, M.D., announces the opening of an office for the general practice of medicine at 50 Division Street, New Haven.

Nicholas A. Mastronarde, M.D., announces the opening of an office for the practice of general surgery at 701 Asylum Avenue, Hartford.

David McGaughey, M.D., announces the opening of an office in conjunction with his father, J. D. McGaughey, M.D., at 261 Center Street, Wallingford.

Samuel R. Millen, M.D., announces the opening of an office for the practice of medicine at 545 Dixwell Avenue, New Haven.

Stewart R. Seigle, M.D., announces the opening of an office for the practice of internal medicine at 1169 Main Street, East Hartford.

Vincent J. Turco, M.D., announces the opening of an office for the practice of orthopedic surgery at 404 Farmington Avenue, Hartford.

CORRESPONDENCE

To the Editor:

Our attention has been called to a certain letter of Dr. Andrew F. Resnisky's appearing in the December 1947 issue of your publication.

May we be permitted to explain to you and, through the columns of your JOURNAL, to your readers that Dr. Resnisky's policy with us, issued in 1944, was a liberal coverage policy, the form of which was approved by the State Insurance Department of Connecticut. There is no fine print and there are no hidden clauses in the policy.

The policy contained broad coverage for both sickness and accident. Every kind of sickness was covered with only four exceptions. These exceptions printed in bold face type as required by law were—

"This policy does not cover death, disability, or other loss sustained . . . while suffering from insanity or mental infirmity; or while the insured is suffering from syphilis or venereal disease."

The Hartford National Bank and Trust Company wrote us that it had been appointed by the Hartford Probate Court as Conservator of the estate of Dr. Resnisky. We presume that is a matter of public record. The question which was raised in regard to Dr. Resnisky's claim related to the meaning of the words "while suffering from insanity or mental infirmity."

It has not been questioned that the disability was caused by mental infirmity.

We believe the language of the policy is clear and unambiguous. The policy was not intended to cover such a case. This is brought out in the provision which is printed in type more prominent than the provisions for benefits. These exceptions in policies of health insurance which eliminate mental infirmity, insanity, syphilis and venereal disease (the last three of these were not involved in Dr. Resnisky's case) are commonly used by many other companies, in fact many policies of health insurance issued by other companies contain additional exceptions.

We respectfully submit, therefore, that the policy language is clear and concise and is not in any manner or to any extent subject to the criticism expressed in Dr. Resnisky's letter.

We shall appreciate it very much if you may see fit to print this explanation of the facts of the case and of the terms of the policy.

Yours very truly,
Mutual Benefit Health & Accident Ass'n
G. J. Cleary,
Vice-President

Suspensation of VA Fees to Physicians

To the Editor:

It has been necessary of late, for this office to suspend certain fees submitted for payment by participating physicians.

The principal reasons for suspension are:

a. Services were not rendered during the period covered by the authorization.

b. Treatments rendered were in excess of those authorized.

It is not the desire of this office to penalize physicians by non payment of services rendered; however, in accordance with existing regulations, authorization for treatment must be issued in advance. It is apparent that in many instances physicians are not taking cognizance of the numbers of treatments authorized nor of the period covered by the authorization. These items are shown on the face of the VA Form 10-2568, titled Authorization and Invoice for Medical Service. For example if 7 treatments are authorized for the period of December 1-December 31, this does not authorize 4 treatments in December and 3 in January.

I am certain that this situation could be easily remedied by the following:

a. The physician should first note the number of treatments authorized and the period covered by the authorization. If it is apparent that the physician cannot possibly render any treatment during the period covered by the authorization, it should be returned to this office for cancellation, and a request for authority to cover the succeeding month.

b. If it becomes apparent during the course of treatment that additional treatments over and above the number authorized are necessary, request for additional treatment should be submitted on Part II, VA Form 10-2690.

c. The physician's invoice submitted on the reverse of VA Form 10-2568 must be in accordance with the services authorized. This means that the number of treatments authorized on the face of VA Form 10-2568 cannot be exceeded by the number of treatments invoiced, the fee must not be in excess of that authorized and lastly, all services shown on the invoice must have been rendered during the period covered by the authorization.

If these simple procedures are followed, it will not be necessary for this office to suspend any fees submitted for payment, which task is a most disagreeable one, I assure you.

I look forward to the continued cooperation that has always existed between this office and our fee basis physicians.

It is requested that if space permits, this letter be disseminated to fee basis physicians via the medium of the Connecticut State Medical Journal.

Thank you for your cooperation in this matter.

Sincerely yours,
S. A. Schuyler, M.D.,
Chief Medical Officer

New York University Group Practice Unit

New York University's medical faculty has organized a group practice medical unit to provide a program of comprehensive year round medical care for wage earner groups. This group is an outgrowth of the University's clinic, opened in 1883, which has provided medical care for more than one million New Yorkers. Inauguration of the Medical Group, which has been characterized as an experiment in the rendering of medical care, means that the number of patients treated a year through the University facilities will increase from 8,000 to between 20,000 and 40,000.

The Medical Group will accept four classifications of patients: (1) industrial wage earner groups covered by contracts with management of labor organizations; (2) cooperative consumer groups covered through an insuring agency; (3) individuals referred by doctors registered with the Group; and (4) patients in need of care by specialty clinics. There will be free choice of physician within the Group which will be a teaching and research facility, medical students accompanying the physicians as far as possible.

The president of the Medical Society of the County of New York and the director of social activities, United Nations Secretariat, both praised the new project.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Robert J. Cook, New Haven
First Vice-President, Mrs. Charles W. Goff, West Hartford
Second Vice-President, Mrs. James Douglas Gold, Bridgeport
Recording Secretary, Mrs. F. Erwin Tracy, Middletown
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

State Notes

December 4, 1947 was another large day in the life of the Woman's Auxiliary to the Connecticut State Medical Society. At 3:30 P. M. a board meeting was held at the New Haven Colony Historical Society. As an open meeting was to follow only the most important items of the day were discussed at this time.

Mrs. G. Gardiner Russell, State legislative chairman, and Mrs. William Mac Shepard, public relations chairman, have done extensive work on the Federal health bills and have condensed them for study groups. This subject was discussed at great length and it is hoped that the study groups may get under way at the earliest possible moment.

The *Hygeia* Chairman, Mrs. Dewey Katz, presented to each board member a copy of a letter to be sent to secondary schools in cooperation with the State Board of Education. There will be more information on this letter at a later date.

A committee was appointed to investigate the feasibility of a small news-sheet to be sent to members at intervals during the year to replace the articles now written in the State Journal. Mrs. Paul S. Phelps, chairman of publicity, is chairman of the special committee, assisted by Mesdames Connors, Barker and Vestal.

Mrs. Edward Wakeman, New Haven, has been appointed chairman of the Committee on Prepaid Medical Service.

The President, Mrs. Robert J. Cook, also appointed the two members of the Board to the nominating committee, Mrs. James D. Gold and Mrs. Creighton Barker.

The mid-year meeting was called to order by the President, Mrs. Cook, at 4:30 P. M. It was a very active meeting, all county presidents and standing committee chairmen gave very interesting two minute reports. After these reports there was stimulating discussion on changing the by-laws to read that the term of office of the president be two years instead of one. No action was taken.

The members then discussed the feasibility of the small newspaper as suggested at the board meeting. It was decided that the committee investigate the matter and report at a future date.

The organization welcomed Dr. Ralph Gilman, chairman of our advisory board, to both the board meeting and the open meeting. Dr. Gilman gave us a short talk at the Board meeting.

The members then joined their husbands at the New Haven Lawn Club for dinner. Following the dinner Dr. James R. Miller discussed A Prepaid Medical Service Plan for Connecticut, and Dr. Louis H. Bauer, Hempstead, L. I., spoke on The World Medical Organization. Mrs. Robert J. Cook presided.

HARTFORD COUNTY

Hartford County is very pleased to announce that the November concert given for the Welfare Fund netted over $175. The concert was a success artistically as well. We are now looking forward to the rummage sale which will be held at the Masonic Temple in West Hartford on February 24 and 25. The money raised will be used toward establishing our Medical Memorial Scholarship Fund. The next board meeting will be held on Tuesday, January 13, at the home of Mrs. Edmund Beizer, 114 Westerly Terrace, Hartford.

NEW HAVEN COUNTY

At the Castle Memorial Building, Waterbury, November 12, the Woman's Auxiliary of the New Haven County Medical Association held its fall meeting.

Mrs. H. Freeman Pennington, president, conducted the business meeting. It was voted by the Auxiliary to contribute $25 to the Connecticut Society for Mental Hygiene to be used in its Christmas work.

Mrs. Frederick W. Roberts, Hamden, chairman of volunteers, will collect articles to be sent as Christmas gifts to the three mental hospitals of Connecticut.

The guest speaker, Mr. N. S. Light who is director of the Bureau of School and Community Services of the State Department of Education, addressed the assembly on Health Plans in Connecticut Schools. He stated that one of the main problems of the school system today is to provide instruction for physically handicapped children. Mr. Light also declared that help is needed to promote a better understanding of what can be done to develop a better and more healthful life in communities. He also feels that there are endless opportunities for an organization such as the Woman's Auxiliary to accomplish results in health education in New Haven.

Mrs. Joseph F. Misuk of Meriden was in charge of the tea after the meeting in the absence of the hospitality chairman, Mrs. John M. Renehan of Ansonia.

A special board meeting was held at the home of Mrs. Lewis C. Foster of Hamden to discuss proposed changes and additions to the constitution and by-laws of the Auxiliary of the New Haven County Medical Association.

MERIDEN CHAPTER

The fall meeting of the Meriden Chapter of the Woman's Auxiliary to the New Haven County Medical Association was held Thursday, November 6, at the home of Mrs. I. S. Otis, Harvard Avenue, Meriden.

Mrs. Raymond V. Quinlan, president of the local chapter, conducted the business meeting. It was voted to establish a project fund which will be used to further health education and other timely objects that may arise from time to time.

Mrs. Cole B. Gibson requested that members of the Auxiliary contribute metal containers to the arts and crafts class at Undercliff.

Mrs. Edward R. Smith, vice-president, was appointed chairman of recruitment of nurses.

NEW LONDON COUNTY

The fall meeting of the Woman's Auxiliary to the New London County Medical Association was held at Lighthouse Inn, November 20, following a luncheon with the president, Mrs. C. Tyson Hewes of Groton in the chair.

Mrs. Willard Morse introduced the guest speaker, Dr. James Dolce of the State Department of Health. He reviewed the history of Public Health Service stressing the need of local health programs, including a full time staff. Communicable diseases, immunization, maternal and infant care are essential in well planned health programs. To further health education, organized committees from civic groups are an important factor.

A business meeting followed. A resolution on the death of Mrs. Harold Wellington was read by Mrs. Julian Ely of Lyme.

Eleanor Mercer Wellington

The entire Auxiliary has been saddened by the sudden death of our president-elect, Mrs. Harold Wellington. The following resume of some of her interests and activities has been contributed by Mrs. Julian Ely.

Eleanor Mercer Wellington was born in New London, the daughter of Frederick W. and Lavinia Palmer Mercer. She attended the public schools in New London and Williams Memorial Institute and graduated from Mount Ida School for Girls in Newton, Massachusetts. She organized and was honorary chairman of the Junior Auxiliary, and was always active in the work of the Auxiliary of the Lawrence and Memorial Hospital. She was always keenly interested in public haelth and for many years was a valued member of the New London Visiting Nurse Association.

Mrs. Wellington was one of the city's most energetic and civic minded women, ever interested in the educational problems of her city, and at the time of her death was serving her fourth term as a member of the School Board.

She had great vitality and industry so that she carried through with imagination and enthusiasm whatever task she undertook. As the second president of the New London County Auxiliary to the State Medical Society, she worked unceasingly to continue the work of the former president. During the past year, as chairman of the Dorothy Labensky Memorial Fund, she led the Auxiliary to the successful completion of one of its outstanding projects.

As a member of the State Auxiliary Board and as president-elect she not only endeared herself to all who came in contact with her but was a constant source of inspiration.

Mrs. Wellington's great interest in the problems of the medical profession began at the the time of her marriage to Dr. Harold Wellington on April 1, 1929. She has one daughter, Frederica, who with her husband survives her. Each day we realize anew how we miss her enthusiastic and happy personality. We extend our deep sympathy to her husband and daughter.

Health Begins at Home

The interest of every American in maintaining his health and the health of his family properly begins at home.

It is at home that children should learn the first principles of health protection. This is not a new process. It has been going on for years in the majority of America's homes.

In the current high interest in national health problems, with adults unwisely in many cases allowing themselves to be swayed by Shangri-La promises of health through politics, the fundamental truth that health should begin at home sometimes gleams but darkly.

It is time that American parents re-evaluate the basic role they play in the education of their children for health, direct their efforts toward this end, and stop listening to the swan songs of political opportunists.

In promoting this sound development, *Hygeia*, the national health magazine of the American Medical Association, has become a major factor. Started in 1923 with a circulation of slightly more than 20,000 copies, this publication now distributes more than 700,000 copies each month to schools, social organizations, hospitals, commercial enterprises, physicians, dentists, nurses, and teachers.

Containing authentic health information written in non technical language easy for anyone to understand, the promotion of this successful modern periodical is an activity of which all participants can be proud.

Members of the Woman's Auxiliary to the Connecticut State Medical Society in 1946 won first place for the largest annual percentage increase in *Hygeia* circulation. This outstanding record means more than the winning of a contest; it means that additional thousands of Connecticut's citizens have access to reliable health information furnished by qualified physician-authors.

There can be no higher devotion than that of aiding our citizens to protect their health and the health of their children.

Monthly Bulletin for Auxiliary

The South Carolina Medical Association now issues a monthly bulletin to serve as a medium of expression for the officers and members of its Woman's Auxiliary. *The Bulletin*, in addition to the above, will continue to endeavor to keep the members of the Auxiliary informed of the most important developments in the fields of medical economics and public relations. This, it is believed, should compensate to some extent for the fact that the *Journal of the South Carolina Medical Association* seldom reaches the members of the Auxiliary.

Tribute to Dr. I. C. Rubin

Seldom has one been honored by a tribute such as the editorial board of the *Journal of the Mount Sinai Hospital, New York*, has paid to the discoverer of the test for tubal patency. The September-October 1947 issue (Vol. XIV, No. 3) includes the contributions of professional colleagues of Dr. Rubin both in this country and abroad. The universality of these contributions serves as an indication of the widespread interest in his attainments.

Dr. Rubin's pre-eminent position in the field of sterility investigation remains unchallenged. His scientific mind coupled with a keenness of intellect and a humanitarian personality have won for him an enviable position in medicine. The contributions in this anniversary volume are not confined to problems in gynecology, but extend into many other fields of medicine, as diverse and extensive as are his friendships.

The foreword of this special issue is written by George W. Kosmak, M.D., and "An Appreciation" by Eli Moschcowitz, M.D. Among the contributors are James R. Miller with "A Contribution to the Technique of Removing Large Cervical Fibromyomas" and Herbert Thoms with "Roentgenography and Roentgenometry of the Pelvis." A bibliography of Dr. Rubin's contributions to medical literature is also included.

The editors are to be congratulated on the Rubin Anniversary Number, both as a testimonial to an eminent gynecologist and as a triumph in publication.

SPECIAL NOTICES

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

January 8—Bright's Disease (by Dr. Harold Pierce, consultant in Inhalation Therapeutics, Hartford Hospital).

January 15—Treatment of Allergic Diseases (by Dr. George Hurwitz, allergist at McCook Memorial Hospital and Hartford Dispensary and Mt. Sinai Hospital).

January 22—Surgical Aspects of Biliary Tract Diseases (by Dr. Samuel Cohn, assistant surgeon, Mt. Sinai Hospital).

January 29—Motion picture, "The Role of Gastroscopy in the Diagnosis and Treatment of Gastric Pathology" (by Dr. Leo L. Hardt, Loyola University).

The meetings of the Conn. Veterans Administration Medical Society are held weekly on Thursday at 8:30 A. M. at the Veteran Administration Regional Office, 95 Pearl Street, Hartford.

ANNOUNCEMENT OF THE SECOND POST-GRADUATE COURSE IN INDUSTRIAL MEDICINE AND SURGERY

To be given under the Auspices of The Yale Institute of Occupational Medicine and Hygiene at the Yale University School of Medicine

February 3 - April 6, 1948

Registration Fee—$15

Sessions will be held from 4:00 to 5:30 P. M., Brady Amphitheatre, Brady Memorial Laboratory, at 310 Cedar Street, New Haven, Connecticut.

This course is open to all physicians, particularly those engaged in full-time or part-time industrial practice.

Inquiries and reservations should be addressed to Dr. R. F. Buchan, clinical director, Yale Institute of Occupational Medicine and Hygiene, 310 Cedar Street, New Haven, Connecticut. Make checks payable to Yale Institute of Occupational Medicine and Hygiene.

February 3—Carcinogenesis in Industry.
Principal Speaker: Dr. W. C. Hueper, assistant director and principal pathologist, Warner Institute for Therapeutic Research, New York City; author, "Occupational Tumors and Allied Diseases."
Chairman: Dr. Harry S. N. Greene, professor of pathology, chairman Atypical Growth Research Unit, Yale University School of Medicine.

February 10—Dermatoses in the Rubber Industry.
Principal Speaker: Dr. Louis Schwartz, medical director, USPHS. (Retired), formerly, chief, Dermatoses Investigation, USPHS; consultant, Industrial Dermatology; co-author "Occupational Diseases of the Skin."
Chairman: Dr. Maurice J. Strauss, clinical professor of dermatology, Yale University School of Medicine.

February 17—Pulmonary Granulomatosis of Beryllium Workers.
Principal Speaker: Dr. Willard Machle, industrial medic consultant, New York City.
Chairman: Dr. Andrew Jackson, medical director, Amer ican Brass Company, Waterbury, Connecticut.

February 24—Health Hazards from Radioactive Materia in Industry and Research.
Principal Speaker: Dr. James J. Nickson, Fellow, Mem orial Hospital, New York; medical consultant, Brook haven National Laboratory; formerly, director, Medic Division, Argonne National Laboratory.
Chairman: Dr. Ernest C. Pollard, associate professor o physics, Yale University; author, "Applied Nuclea Physics."

March 2—Basic Physiological Considerations in Aviation.
Principal Speaker: Dr. John F. Fulton, Sterling professo of physiology, Yale University School of Medicin chairman, University Department of Physiology.
Chairman: Dr. C. N. H. Long, Sterling professor o physiological chemistry; dean, Yale University Scho of Medicine.

March 9—Minor Surgery in Industry.
Principal Speaker: Dr. Lewis Giffen, F.A.C.S., diploma American Board of Surgery; assistant surgeon, McCoo Memorial Hospital, Hartford; Newington Cripple Children's Hospital, Newington; staff, Hartford Ho pital, St. Francis Hospital, Hartford; consulting su geon, Hartford Small Plant Industrial Medical Servic
Chairman: Dr. Samuel C. Harvey, professor of surger (Oncology), Yale University School of Medicine.

March 16—The Contribution of the Consulting Industri Psychiatrist.
Principal Speaker: (To be announced).
Chairman: Dr. Frederick C. Redlich, executive office Department of Psychiatry and mental Hygiene; assis ant professor of psychiatry and mental hygiene, Ya University School of Medicine.

March 23—The Back in Industry.
Principal Speaker: Dr. John J. Moorhead, professo clinical surgery, Columbia University; author, "Clinic Traumatic Surgery."
Chairman: Dr. Malcolm S. Eveleth, assistant professor orthopedic surgery, Yale University School of Mec cine.

March 30—Trauma from Noise in Industry.
Principal Speaker: Dr. Norton C. Canfield, associate pr fessor of otolaryngology, Yale University School Medicine.
Chairman: Dr. Albert S. Gray, director, Bureau of Indu trial Hygiene, Connecticut State Department of Healt

April 6—The Injured Worker: Physiological Considerations in Speeding Convalescence.

Principal Speaker: Dr. J. A. F. Stevenson, research assistant, Physiological Chemistry, Yale School of Medicine; formerly, major, R.C.A.M.C.; advisor in nutrition to Canadian Army Overseas.

Chairman: Dr. Ronald F. Buchan, clinical director, Yale Institute of Occupational Medicine and Hygiene.

RURAL HEALTH CONFERENCE

The third annual National Conference on Rural Health ill be held in Chicago, February 6 and 7.

Featuring the health problems of the rural child, the onference will be sponsored by the Committee on Rural Iedical Service of the AMA in cooperation with the Amer- an Academy of Pediatrics and representative farm or- anizations. The AMA committee, headed by F. S. Crockett, .D., of Lafayette, Ind., is composed of 11 physicians.

More than 40 speakers are on the program for the two ay session. On the afternoon of the opening day, four rm youths, representing the National Farmers Union, the merican Farm Bureau Federation, the National Grange id the National Cooperative Milk Producers Federation, ill discuss the subject: "Rural Youth Looks at Health." he youths will be guests of the American Medical Associa- on during their stay in Chicago.

POSTGRADUATE COURSES AT MT. SINAI HOSPITAL, NEW YORK

Symposium in Medicine (February 2 to April 3, 1948) in rdiovascular Diseases, Gastro-intestinal Diseases, Diseases the Liver, Kidney, Chest, Allergy, Diseases of Metabol- n, Endocrinological Diseases, Venereal and Skin Diseases, ematology.

Individual courses, varying in length (January 5 to May 1948) in Elementary and Advanced Electrocardiography; eriatrics, Gynecology, Bedside Clinics in Heart Diseases; ecent Advances in Neurology and Psychiatry; Psychiatry General Medicine; Surgical Pathology, Clinical Pediatrics, ysiology; Surgery of the Gastro-intestinal Tract and mposium in Ophthalmology.

For further inforamtion address the Registrar for Medical struction, The Mount Sinai Hospital, Fifth Avenue and oth Street, New York 29, N. Y.

POSTGRADUATE INSTITUTE IN DETROIT

The Second Annual Michigan Postgraduate Clinical In- tute will be held at the Book-Cadillac Hotel, Detroit, ednesday-Thursday-Friday, March 10-11-12, 1948. Forty- ne outstanding clinicians and lecturers will present a ncentrated three-day post-graduate course covering the west developments in medicine, surgery, obstetrics, pedi- ies, dermatology, ophth-otolaryngology and general prac- e.

Two evening sessions will be held, the Wednesday night presentation being a "question box" and the Thursday evening program being a panel discussion on "First Aid to the Acutely Injured Patient."

All members of the American Medical Association and of the Canadian Medical Association are cordially invited to attend the Michigan Postgraduate Clinical Institute. No registration fee.

MISSISSIPPI VALLEY MEDICAL SOCIETY 1948 ESSAY CONTEST

The Eighth Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1948. The Society will offer a cash prize of $100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the Thirteenth Annual Meeting of the Mississippi Valley Medical Society to be held in Springfield, Ill., September 29, 30, October 1, 1948, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5000 words, and must be received not later than May 1, 1948. The winning essay in the 1947 contest appears in the January 1948 issue of *Mississippi Valley Medical Journal* (Quincy, Illinois).

Further details may be secured from Harold Swanberg, M.D., secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Illinois.

BRITISH PUBLICATIONS AVAILABLE

All periodical publications of the British Medical Association are now obtainable through Grune & Stratton, Medical Publishers, 381 Fourth Avenue, New York 16, New York, who have been appointed by the Association sole agents for the United States beginning with January 1948.

The journals are: British Medical Journal, published weekly, $14 a year; Abstracts of World Medicine, published monthly, $13 a year; Abstracts of World Surgery, Obstetrics and Gynecology, published monthly, $9 a year.

Quarterly journals: uniform subscription rate $5.50 a year: Annals of the Rheumatic Diseases; Archives of Disease in Childhood; British Heart Journal; British Journal of Industrial Medicine; British Journal of Pharmacology and Chemotherapy; British Journal of Social Medicine; British Journal of Venereal Diseases; Journal of Clinical Pathology; Journal of Neurology, Neurosurgery, and Psychiatry; Thorax.

OUR NEIGHBORS

Massachusetts

The new editor of the *New England Journal of Medicine* is Joseph Garland, M.D., who succeeds Robert N. Nye, M.D., deceased. Dr. Garland has resigned as secretary of the Massachusetts Medical Society.

New Jersey

The Medical Society of New Jersey through its president, Royal A. Schaaf of Newark, has proposed that, to overcome the shortage of nurses in New Jersey, the training of graduate nurses be carried out at Rutgers University, the expense to be borne by the State. The Society also proposed that the public make a larger contribution to the hospital care of "the sick poor" in order to diminish the financial burden now carried by private patients.

A state-wide, four-point program "to improve the health of the school children of New Jersey" is now being sponsored by the State Department of Education of New Jersey, the New Jersey Medical Society and its Woman's Auxiliary. The program was developed after a year of conferences between Wilson G. Guthrie, M.D., of Trenton, director of health, safety and physical education of the State Department of Education, and Samuel Blaugrund, M.D., Trenton, chairman of the public health committee of the medical society. Royal A. Schaaf, M.D., Newark, president of the society, has recently sent to the president of each county society a letter requesting cooperation in the program's development.

The four points of the program are:

1. Wherever possible, the present "routine," assembly-line physical examinations of school children should be abandoned in favor of individualized studies by qualified physicians, properly remunerated. The child should be stripped to the waist. For obvious reasons, one or both parents should be present at the examination.

2. As a minimum, the examinations should be held on admission to school, to the fourth grade, to the eighth grade and to the twelfth grade.

3. Each county superintendent should be required to add a psychiatrist to the county school system—possibly on a consultative rather than full-time basis. One psychiatrist might cover more than one of the smaller counties.

4. All school teachers and adult school personnel should be x-rayed for tuberculosis every year rather than every third year, as at present.

The Woman's Auxiliaries of the various county medical societies are taking the initiative in organizing county councils to interest local authorities and voluntary agencies in each community in the program. In general the county councils will include representatives of the school physicians, school nurses, dentists, psychiatrist, boards of education teachers, parent-teachers' associations, county medical societies and other county agencies directly concerned with school health.

The Medical-Surgical Plan of New Jersey (for prepaid medical care) on September 30, 1947 reported an enrollment of 136,975 persons. Schedule of benefits has been changed to allow an increase for anesthesia (except local) from $10 to $12.5 except for tonsillectomies and vaginal deliveries, and for inguinal and femoral herniorrhaphies from $75 to $100 with the bilateral operation at $125.

New York

The Medical Society of the State of New York has increased the dues for 1948 from $10 to $15.

The Rochester Chapter of the American Red Cross has set up the first center for the National Blood Program. The local center will cover the eleven-county Rochester area taking in seventeen Red Cross chapters and a population of about 1,000,000 persons.

The Medical Society of the County of Westchester celebrated its sesquicentennial on November 17, 1947 by a dinner at the Waldorf-Astoria, New York City. To commemorate the occasion the Society directed the publication of a volume entitled "History of the Medical Society of the County of Westchester." Laurance D. Redway, M.D., is the compiler.

Consolidated Edison Company of New York, Inc., has added a blood bank service available to employees, their wives and dependents. Blood of the correct type and Rh factor is delivered when required by the Blood Bank of Queens County, Inc. The employee using the service is expected to replace the blood within ninety days, personally or by a substitute.

NEWS
from County Associations

Fairfield

Bernard F. Smith, M.D., lieutenant, USNR, Norohon Heights, is now attached to the Regular Navy recruiting staff in Connecticut. He will make scheduled visits to all recruiting stations in Fairfield and New Haven Counties. All Navy applicants from the Westport-Norwalk-Greenwich area will be given physical examinations at the South Norwalk Recruiting Station in the South Norwalk Post Office Tuesdays and Saturdays.

Dr. Smith is a graduate of the University of Notre Dame and the New York Medical College. During the war he served with Destroyer Mine Squadrons and had his medical offices on the U.S.S. Hambleton. From that ship he took care of the sick and wounded in the other eight ships in the squadron. Prior to duty with the Naval recruiting staff in this State he was attached to the Third Naval District Medical staff in New York City.

Gray Carter, M.D., has been elected president and Sidney Thompson, M.D., second vice-president of the Greenwich Branch of the Connecticut Cancer Society.

Frank H. Lahey of the Lahey Clinic in Boston was the speaker at the meeting of the Bridgeport Medical Association held in the auditorium at St. Vincent's Hospital on December 2. Dr. Lahey gave an interesting and informative talk on "Lesions of the Colon, Rectum and Terminal Ileum," touching at some length on carcinoma of the rectum, ulcerative colitis and regional ileitis. The attendance at this meeting was the largest ever to attend a meeting of the association. A delicious buffet followed the meeting. This being the annual meeting of the association, the nominating committee consisting of Drs. Booc, Smykowski and Watts, presented a slate of officers for the year 1948. Elected to office for the coming year were: President, Irving B. Akerson; President-elect, Daniel F. Keegan; Vice-President, Mac L. Harshbarger; Treasurer, Edward P. Kemp; Medical Secretary, Edwin R. Connors. The annual report of the treasurer was read and the association is in a healthy financial condition. The secretary reported in his annual report a very successful year under the able guidance of the president, Charles W. Nichols. The attendance at the monthly meetings has doubled since the meetings have been held alternately in Bridgeport and St. Vincent's Hospitals. The association added the names of thirty-five physicians to its roster during the past year and at the present time has two hundred and sixty-four members. At the meeting the following physicians were elected to membership: H. Patterson Harris, Jr., Eli B. Ives, Raymond A. Sterett, Robert H. Abrahamson, Isidore Yasser, Stuart L. Joslin, William T. Corbett, William A. Donnelly. The annual banquet of the association will be held at the Algonquin Club in Bridgeport on Wednesday evening, January 21, 1948. Joseph Watts is the major-domo in plans for the event and everyone is looking forward to a bang-up evening as Joe has never failed us in the past.

Attending the clinics at the special courses in cardiology at the Montefiore Hospital in New York are George A. Buckhout and A. Boswell James. Ben Horn has returned from an intensive course of study in New Haven, in cardiology. Maxwell Bogin and John Buckley attended clinics in pediatrics in Texas in December. We are happy to see the smiling countenance of Pat Carroll in the wards of St. Vincent's Hospital, looking fit after his serious illness. Maxon Eddy has taken over a surgical service in Bridgeport Hospital. H. Bertram Lambert is at the Veterans Hospital in Rocky Hill as surgeon and his presence is missed in the staff room at the Bridgeport Hospital. His ability as a weather prognosticator is missed by all those who sought his advice on golf dates, excursions and outings. We wish him the best of luck in his new position.

Marcus Backer of Bridgeport has written an article entitled "The Examination of the Hypertensive Patient" which appears in the November issue of the *American Journal of the Medical Sciences.*

Hartford

At the 145th semi-annual meeting of the Hartford County Medical Association held on October 28, 1947 the following changes in the by-laws were recommended by the Board of Directors and duly passed:

ARTICLE III
MEMBERSHIP
Section 1

Second sentence (which now reads) "An Applicant must have resided and practiced in the State at

least one year after the issuance of his Connecticut license and in Hartford County or an immediately adjoining one at least six months immediately preceding the date of his application," be changed to read as follows: "An applicant must have resided and practiced in the State at least one year after the issuance of his Connecticut license and in Hartford County or an immediately adjoining one at least six months immediately preceding the date of his application *except that the residence and waiting period may be waived in the following manner.* The applicant who is duly licensed and has actually begun practice presents, with his application, a petition that the waiting period be waived, signed by ten members of the County Medical Association. The Board of Censors shall report upon such an application favorably or unfavorably to the County Association. Upon two-thirds vote, Article III, Section 1, may be suspended in regard to the waiting period of the applciant and his name may be balloted upon as if he had fulfilled the full requirements of residence and practice in the State and/or County."

Article IV
Student Members
Section 1

Any person whose legal or family residence is in Hartford County who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 478 F of the Cumulative Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Association. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remeuneration, may become Student Members of the Association.

Section 2
Application or Membership

Such membership shall be obtained by applying to the Board of Censors of the Association on a form provided for that purpose and election shall be by vote of a majority of the Board of Censors.

Section 3
Privileges

1. Student members shall enjoy all of the rights and privileges of membership in the Association except that they shall not be eligible to vote or to hold office.

2. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this County or in an immediately adjoining one, he shall be eligible at once for election to active membership in the Hartford County Medical Association.

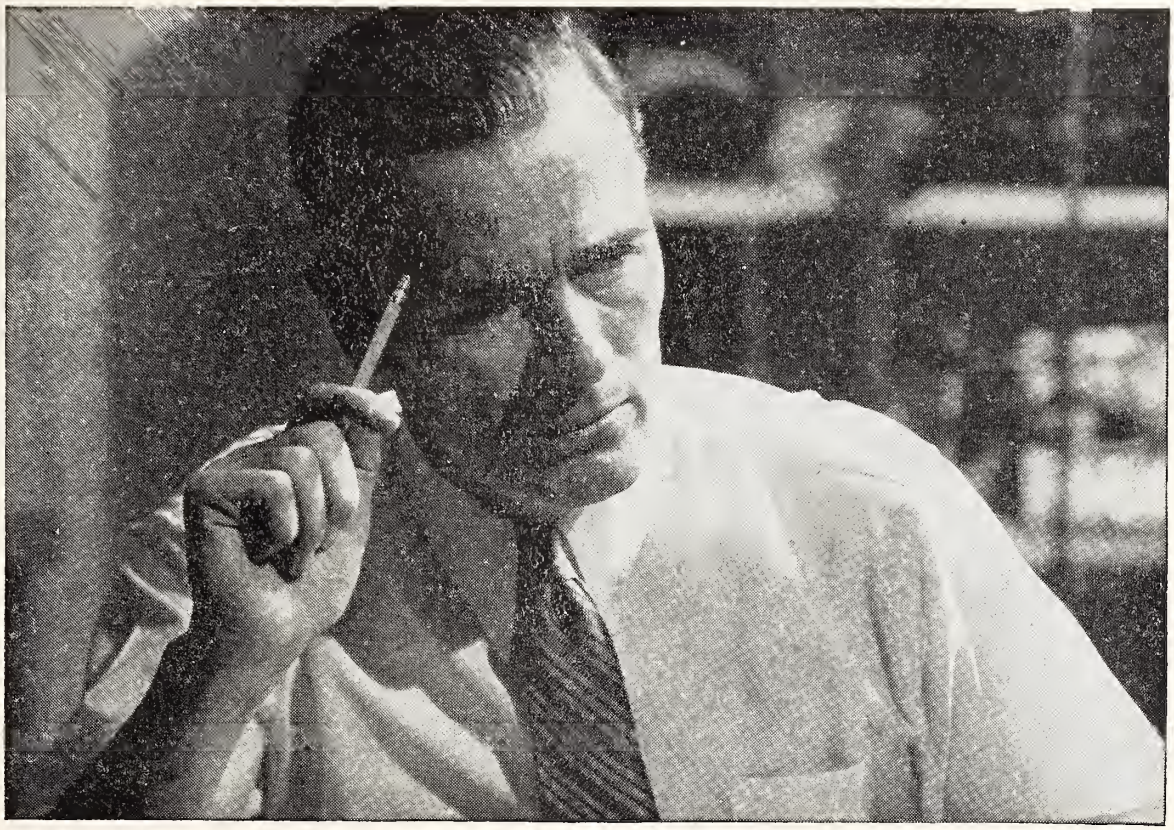
The attendance at this semi-annual meeting of the County Associtaion was exceptionally good but it represented only 25 per cent of the total membership.

The meeting of the Hartford Medical Society on November 17, 1947 was characterized by its president, C. C. Burlingame, as marking an epoch in history. Professor Robley D. Evans of Massachusetts Institute of Technology demonstrated in a very realistic manner the fundamental principles of radioactivity in discussing his subject, "Radioactive Isotopes and Their Clinical Applications." Dr. Evans is a brilliant speaker and made his subject extremely interesting to those who were fortunate enough to obtain a seat.

Philip R. Partington has been named physician in the clinic at Hartford Hospital. Dr. Partington's appointment is part of an expanding outpatient program at the hospital designed to provide a more thorough system of investigating patients referred by outside physicians. His work will consist primarily of coordinating the work done in the specialty clinics with that done in the diagnostic clinic. Dr. Partington, a graduate of Yale University in 1937 and former Hartford Hospital intern, practiced medicine for several years in Great Barrington, Mass. During the war he was a naval officer serving at Okinawa and China. He is now a lieutenant commander in the U. S. Naval Reserve on inactive duty.

Otto G. Wiedman, a member of the Hartford Hospital neurological department, presented a paper on "The Diagnosis and Treatment of Epilepsy" at the southern regional meeting of the American College of Physicians in Tampa, Florida, in December.

Dr. William J. Kucewicz, health officer of the town of Enfield for the past five years, has resigned this office and has reported at Richmond, Va., for a year of study in allergy at the Graham-Thom Clinic to which he has received a special appointment. The selectmen have named Dr. Thornton Vail, Enfield medical examiner, to succeed Dr. Kucewicz.



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Sure saving because it's automatic—U.S. Savings Bonds

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Ralph M. Tovell, chief of anesthesiology at the Hartford Hospital, presented a paper on the new applications of procaine by intravenous injection at the second annual meeting of the American Society of Anesthesiologists held in New York in December.

Litchfield

The 183th semi-annual meeting of the Litchfield County Medical Association was held at the Torrington Country Club in Goshen on October 7, 1947. The Councilor, Floyd A. Weed, reported on the activities of the council and suggested that the Litchfield County Medical Association should consider becoming more active in medical affairs. Following this suggestion there was considerable discussion by the members and a motion was passed that the president appoint a committee to study the organization and objectives of the Litchfield County Medical Association. This committee should consist of six members selected as to their ability and geographical location and should be empowered to call upon the officers of the medical association, chairmen of the committees, and the officers of the Connecticut State Medical Society for any information necessary to complete their investigation.

The following physicians were elected to membership in the Association: James H. Linder, transferred from the Medical Society of the County of New York; Frederick C. Gevalt, transferred from the Massachusetts Medical Society, also veteran of World War II; and Robert P. Noble, Sharon; Daniel P. Samson, Thomaston; Benjamin Katzin, Torrington; John M. Street, New Milford, all veterans of World War II.

A motion was passed that the president appoint a committee of five to be known as the Litchfield County Medical Association Cancer Committee, one of these members to be the secretary.

Dr. John C. Leonard of Hartford gave a very instructive address on the subject of hypertension. At the close of his address he distributed copies of a diet which he had found of considerable value in treating this symptom. There were numerous questions from the audience.

Jerome Stuart Chaffee, practicing physician in Sharon since 1903, died at his home in that town on November 26, 1947 at the age of seventy-four. Dr. Chaffee, among other accomplishments, served four years in the U. S. Army following active duty in the U. S. Navy during the War with Spain, fo many years was a health officer and medical exam iner for the New York Central Railroad, and wa one of the founders of and for thirty-five years director of the Sharon Hospital.

New Haven

Harold S. Appell of West Haven has passed th examinations and is now a diplomate of the Ameri can Board of Dermatology and Syphilology.

Simeon Cohen of Meriden died in the hospital o that city on November 2 after an illness of about year. Past Commander of Meriden Post, No. 45 American Legion, Dr. Cohen was accorded ful military honors at his funeral.

William Finkelstein, John H. Foster and M. H Ruby will arrange for the observance in Waterbury of National Heart Week in February. The three ar members of the New England Heart Association.

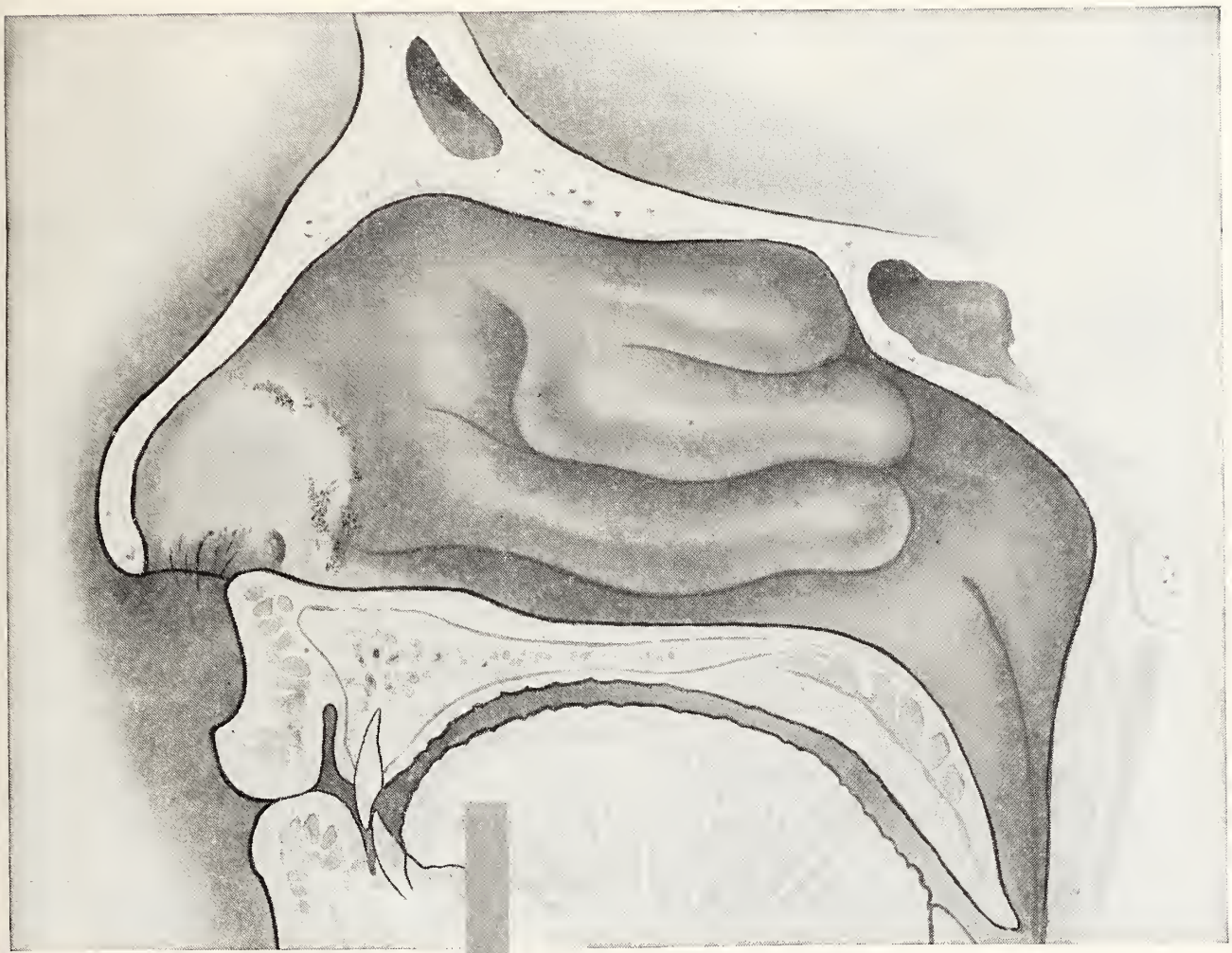
Coroner James J. Corrigan has announced th appointment of Dr. H. Bruno Arnold, of Beeche Road, Woodbridge, as medical examiner for Wood bridge and Bethany. Dr. Arnold was graduated fron Yale College in 1923 and from Yale Medical Schoo in 1926. He interned in the Newark, N. J., Hospital

New London

Clarence G. Thompson, M.D., county news edito from New London County for the JOURNAL, ha been appointed health officer of Norwich for period of four years. Dr. Thompson succeeds Ed ward G. Brophy, M.D. At present Dr. Thompson i in a Boston hospital convalescing from a recen operation.

Windham

E. H. (Wilbur, or is it Orville) Basden has re cently obtained an airplane pilot's license. Witl much enthusiasm our air-minded local physician ha for the past several months amused himself by flyin hither and yonder over southern New England, an amused his colleagues with the accounts of his ad ventures and exploits. He states that he is doing thi solely as a pasttime and makes no pretense of needin this means of conveyance to make rounds on hi patients. As far as we know, Dr. Basden is the firs M.D. in Windham County while in active practice t have taken up the pastime of flying and carried i through to pass successfully the examination neces sary to obtain a license.



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John G. Raymer has given up his association in Willimantic where he has been for better than the last one and one half years, the period since his discharge from the Service. He has taken up an office again for his general practice in Norwich, Connecticut, where he was located before the war.

The recent study of the hospital bed situation in Connecticut has accentuated the point that Windham County is short an appreciable number of general hospital beds.

In Putnam a campaign to raise funds for a memorial wing of the Day-Kimball Hospital is about to be undertaken.

David H. Bates of Woodstock was among those from this area who have received World War II Victory medals distributed by Chief Navy Recruiter E. A. Weidner. Dr. Bates served as a lieutenant commander in the Medical Corps of the USNR.

Ophthalmology Research Fellowships

Fellowships for research in ophthalmology have been granted to the medical schools of Harvard and Yale Universities by The Eye-Bank for Sight Restoration, Inc.

Recipients of fellowships will devote themselves chiefly to problems related to the cornea. It is expected that the knowledge thus acquired will aid in the conservation of vision and the restoration of sight among thousands of individuals. One of the principal objectives of research carried on at the present time is the discovery of a method for the preservation of corneal tissue for a period longer than seventy-two hours.

The Research Fellows are Dr. Thomas Duane, for work at the Howe Laboratory of Harvard University Medical School to investigate the metabolism of the cornea under various conditions of storage with the idea of determining what basically takes place which deleteriously affects corneal tissue and makes it unsuitable for corneal transplant, and Dr. David Freeman, for work at the Yale University School of Medicine, whose problem it will be to attempt to determine whether embryonic tissues can be grafted upon members of the same species and upon other species. This is an experiment in tissue transplantation.

NEW BOOKS IN REVIEW

PHARMACOLOGY, THERAPEUTICS AND PRESCRIPTION WRITING—FOR STUDENTS AND PRACTITIONERS. (Fifth Edition.) *By Walter Arthur Bastedo,* PH.G., PH.M.(Hon.), M.D., SC.D.(Hon.), F.A.C.P., Consulting Physician, St. Luke's Hospital, N. Y.; St. Vincent's Hospital, Staten Island, and the Staten Island Hospital; President, U.S.P. Convention 1930-40; Member Revision Committee, U.S.P., Formerly Curator of the N. Y. Botanical Garden; Attending Physician, City Hospital, N. Y.; Instructor in Pharmacology, Cornell University; Associate in Pharmacology and Therapeutics and Assistant Clinical Professor of Medicine, Columbia University *Philadelphia and London: W. B. Saunders Company* 1947. 840 pages, with 82 illustratinos. $8.50.

Reviewed by DESMOND D. BONNYCASTLE

In the fifth edition of this textbook the arrangement and presentation of the subject material adheres very closely to that of the previous edition in 1937. New sections of course have been added. Some of these new sections deal with the sulfonamides and the antibiotic compounds, with blood fractions, amino acids, anticoagulants and coagulants, demerol, folic acid, DFP, and the antihistaminic drugs benadryl and pyribenzamine, antimalarial drugs, and the use of BAL in the treatment of arsenical poisoning.

The purpose of this text is to supply the student and physician with information regarding the medicaments that are available, what they do, and how they may be used. However, there are places in it where one wishes that the author, rather than listing the preparations available, had expanded the subject material to a greater extent including more discussion of the effects and possible mechanism of action. Nevertheless the text, while covering the older material, furnishes up-to-date information about many of the new compounds.

INTERNAL MEDICINE IN GENERAL PRACTICE. (Second Edition.) *By Robert Pratt McComb,* B.S., M.D., F.A.C.P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. *Philadelphia and London: W. B. Saunders Company.* 1947. 741 pp. with 122 illustrations. $8

Reviewed by RALPH E. DURKEE, JR.

This is the second edition of a small volume which covers the highlights of internal medicine in a manner intended especially for the general practitioner. It might be called an outline of internal medicine and is well suited to the purpose for which it is intended as it offers a tremendous amount of knowledge in a condensed and quickly accessible form. The material is well selected and expresses the latest information in this field. It might be expanded to advantage

even for the general practitioner, as such a common and important condition as acute myocardial infarction is dealt with in a page and a half. The book will be of limited value to the internist except for quick review, as he will want more detail about each subject.

The chapter on the Use of the Sulfonamides, Penicillin, and Streptomycin is an excellent piece of work. All the essential facts are presented in compact and accurate form and the recommendations for use of these therapeutic agents show rare good judgment. The chapter on Psychiatric Disorders is to be commended not only for its factual presentation but also because it emphasizes diagnosis by direct approach rather than by the expensive and time consuming method of exclusion. It is suggested that penicillin might be added to the treatment of agranulocytosis resulting from sulfonamide therapy as outlined on page 445, and BAL is offered as an advance over sodium formaldehyde sulfoxalate in the treatment of bichloride of mercury poisoning which is presented on page 150.

There are a few typographical errors which do not detract from the usefulness of the book. For its massive accumulation of accurate, up-to-date information this small volume cannot be excelled. It is recommended without reservation to the general practitioner for quick reference or for review of the field of internal medicine.

DIABETES AND THE DIABETIC IN THE COMMUNITY. By Mary E. Tangney, R.N., Diabetic Supervisor Hartford Hospital, Hartford, Connecticut. *Philadelphia and London: W. B. Saunders Company.* 1947. 259 pp. $2.75.

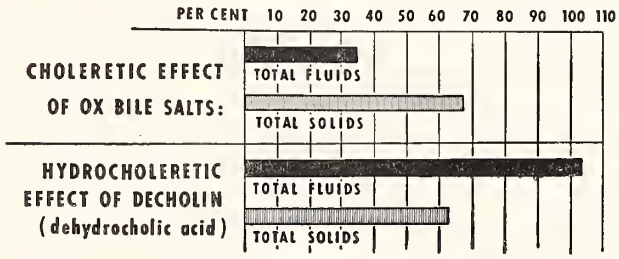
Reviewed by STANLEY B. WELD

It would be difficult by even the greatest stretch of the imagination to find anything pertaining to the subject of this volume which the author has omitted. The first triumph is a foreword by Priscilla White, an authority on diabetes, calling attention to the role of the diabetic nurse today. Dr. White gives the reader a little of Miss Tangney's background of experience at the Baker Clinic in Boston and, what is of equal importance, her first hand knowledge as a patient of the problems of the diabetic. In the preface which follows, the author points out the emphasis in her book focussed on the teaching of the diabetic person out in the community. The influence upon the author of Dr. Elliott P. Joslin and of Dr. Priscilla White with their limitless fund of knowledge of and experience with diabetics is apparent from page to page.

This is a bok for the diabetic nurse. There are some chapters in it which should be read by every physician who comes in contact with diabetics— and most physicians do. It is a book which may be given to the intelligent diabetic patient at the discretion of the physician or diabetic nurse. The historical chapters are brief, bringing the reader up to date on the problem of diabetes and even including a brief discussion of the advantages of a diabetic fund.

The chapters on insulin and diet are complete, even to the last detail, which is often the cost of a drug or a food. The reader gets a sample of Miss Tangney's convincing style as a writer in the opening sentence of the chapter on Diabetic Coma. Note this: "Diabetic coma presents one

DECHOLIN HYDROCHOLERESIS Encourages Biliary Tract Drainage



● **Percentage Increase in Composition and Quantity of Bile Flow**

Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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of the most fascinating, dramatic, yet thoroughly discouraging episodes in the panorama of medical emergencies." The author is at her best, however, in the chapter on Diabetes in Childhood and Adolescence. It shows an intimate knowledge of child psychology. The book ends with a discussion of Dr. White's theories and method of treating diabetes in the pregnant woman, and a closing chapter on The Diabetic in the Community.

The publishers have bound this volume attractively, the print is legible and there are sufficient illustrations, charts and subheadings to attract the casual reader and guide the student. Each chapter is followed by a list of references pertinent to the topic under discussion.

There have been several diabetic manuals writen and many textbooks covering the various phases and complications of diabetes, as well as the overall subject itself. This is the first concise volume of its kind particularly designed for use by the student and the graduate nurse. It effectively fulfills an essential need.

BENJAMIN SILLIMAN 1779-1864 – PATHFINDER IN AMERICAN SCIENCE. By John F. Fulton and *Elizabeth H. Thomson. New York: Henry Schuman.* 1947. 294 pp. $4.

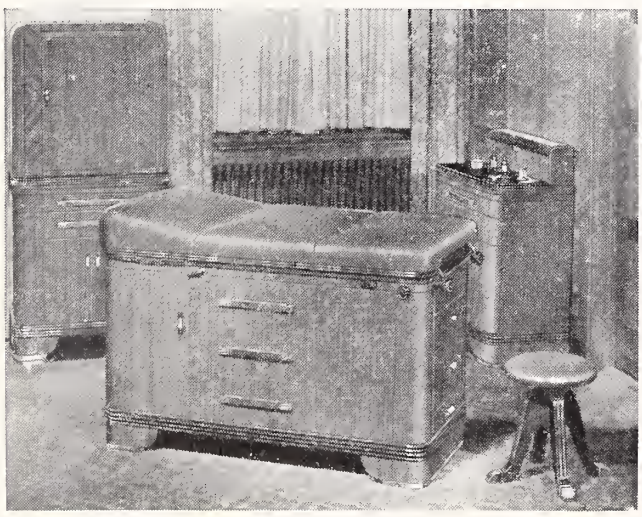
Reviewed by STANLEY B. WELD

Yale has many historical figures of note to whom her alumni owe an immeasurable debt of gratitude for their courage, vision and unselfish years of devoted service. One of these was Benjamin Silliman who occupied the first chair in chemistry at Yale College and the Medical Institution, established the first course in geology in the country, founded the first successful journal of science, and was the driving spirit behind another "first" in American education, the college art gallery. One is impressed, in reading this excellent volume of Fulton and Thomson's, by the pioneering instinct of the man and by his versatility. He brought to Yale the foundations of a real department of science, the value of which her traditional rival at Cambridge did not appreciate until several years later.

The story of Benjamin Silliman's journey to Europe by packet to acquire knowledge in and secure equipment for his first course in chemistry is a thrilling one. His years as professor without a laboratory, the trials of securing suitable quarters for his classes, his interest in geology and minerology, his value to the Medical Institution, and his contributions to mining and chemical industries—all are graphically recounted in this volume. To this is added the charm of New Haven, the college town of the mid-nineteenth century, in such a fashion it would seem as though one or both the authors must bave been part of that early picture.

Benjamin Silliman was not circumscribed by the usual geographical boundaries of those days of difficult travel. We find him in 1844 traveling by steamer to New York, thence by rail, stage and steamer again over the Alleghanies, down the Ohio, and up the Mississippi. From thence the journey by horse over into the coal regions of Illinois is an exciting

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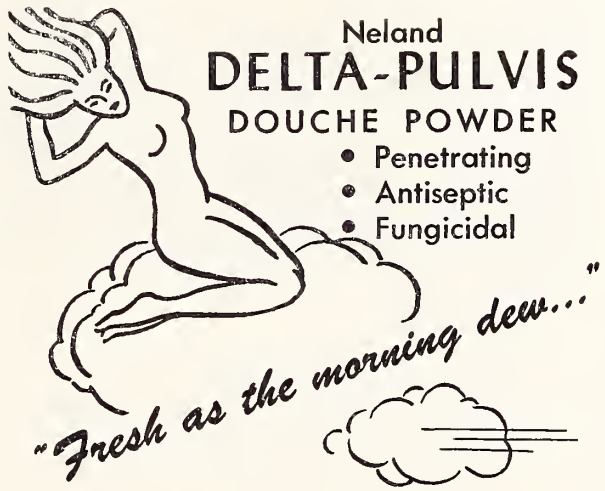


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tale in itself.

Physicians in Connecticut will read with interest of Benjamin Silliman's role in the formation of the medical school at Yale and of his part in securing a medical faculty. It is little wonder that before he reached the end of his career at eighty-five he had laid the foundations for the Sheffield Scientific School at Yale. His rare magnetic power for kindling the enthusiasm and awakening the cooperation of all whom he wished to reach marked him as a leader of rare talent and ability.

This volume is publication No. 16 of the Historical Library at Yale University School of Medicine. Its plain blue cloth binding with gold lettering bespeaks the rich simplicity of the character portrayed within its covers. The illustrations are numerous and of excellent quality. The only detracting feature of the whole book is the frequent change from 10 point to 8 point type when quoting from source material.

Benjamin Silliman well may be claimed by Connecticut medicine as one of her own.

LABORATORY MANUAL OF MICROBIOLOGY FOR NURSES. By Elizabeth S. Gill, B.S., R.N., Instructor in Nursing, College of Physicians and Surgeons, Columbia University, and *James T. Culbertson,* PH.D., Professor of Bacteriology and Parasitology, University of Arkansas School of Medicine. *New York: G. P. Putnam's Sons.* 1947. 116 pp. $1.50.

Reviewed by EARLE K. BORMAN

This loose-leaf manual is nicely designed for use in the laboratory for recording data on the experiments performed and pertinent notes on outside reading and study. It is based upon a series of laboratory exercises in microbiology which should serve to acquaint the student nurse with the fundamental principles of laboratory work and with the general principles of handling pathogenic organisms. It is assumed that the laboratory work will be supplemented by well integrated lectures and by compulsory reading of assigned references. The approach of the authors to the practical problem of instructing student nurses in microbiology shows imagination and careful thought. No attempt has been made to present a course which will turn out finished laboratory workers but the student should derive a sufficient understanding of basic microbiological principles to permit intelligent application in routine nursing procedures.

Typographical errors are not infrequent in this manual although minor for the most part. It is disturbing to contemplate a person who has studied microbiology going through life calling the genus *Aspergillus* by the euphonious but incorrect name "*Asperilligus*," a possible result of one such typographical error.

A TEXTBOOK OF CLINICAL NEUROLOGY—WITH AN INTRODUCTION TO THE HISTORY OF NEUROLOGY. (Sixth Edition.) *By Israel S. Wechsler* M.D., Clinical Professor of Neurology, Columbia University, N. Y.; Neurologist, The Mt. Sinai Hospital; Consulting Neurologist, Montefiore Hospital and Rockland State Hospital, N. Y. *Philadelphia and London: W. B. Saunders Company.* 1947. 829 pages with 162 illustrations. $8.50

Reviewed by GEORGE A. GOSSELIN

This 800 page, 6th edition of Dr. Israel Wechsler's "Textbook of Clinical Neurology," takes it place as a welcome successor to the other five.

The re-arrangement of the subject material is different though interesting. One notes the practicality of the chapter plan beginning with the physical neurological examination and a description of the technique for the proper inter-

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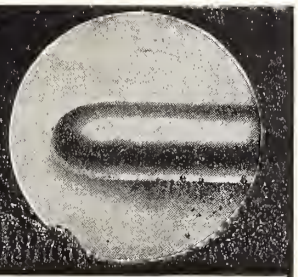
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pretation of reactions based on anatomy and physiology. This includes a clear and simple approach to the studies of the various phenomena associated with disturbance in sensation, coordination, etc, as well as the technique and evalution of laboratory tests.

Following the section on physical examinations is a simple, concise but practical and sufficiently inclusive data relative to psychological diagnosis. This makes for a logical sequence of procedure in the study of a case. There are few works on general neurology which consider sufficiently the correlation of the psychological and neurological. It is gratifying to note Dr. Wechsler's insistence on a physical examination in this type of case. The various intelligence tests described by the author's brother, David Wechsler, are easily understood. These include the commonly used and accepted tests as the Wechsler-Bellevue, the Rorschach, the Kuhlmann and others. Certainly any general practitioner situated at a distance from cities or specialists should welcome them for his local and at times urgent needs, especially in medicolegal affairs.

Organic brain changes due to vascular, neoplastic, infectious and endogenous metabolic toxic causes contribute to keeping one up to date in this rapidly changing field. The interpretation of regional pathology, always a problem even with the best trained, is described without too heavy technical language, especially the "name" syndromes. Standard practice along this line, coupled with conciseness, has permitted the author to cover considerable ground. This also obtains in relation to the studies of traumatic and congenital conditions as well as the autonomic syndromes. Neurosurgical indications such as for lobotomies. etc., are a welcome addition.

The newer therapy in relation to organic syndromes, as well as those having to do with deficiency diseases, is abreast of the times. Drug therapy for the spasmoses, epilepsy, multiple sclerosis, etc., has been properly and conservatively evaluated. The author's own experience and the numerous articles in the last few years relative to these subjects especially, have caused the profession to respect his opinions and practical deductions.

The author's explanation of the neuroses and allied states with a description of psycho-analysis is kept within the field of reality and sound practice. It is regretable that voluminous, uninhibited, lay publications on these subjects could not be kept at this level and limited to the medical profession as the author has seemed to do. There would be less laughter provoked by "cracks" made on the stage and screen and more respect for this highly scientific, serious and all important phase of medicine.

One wishes that the discussion of the vegetative mechanisms might have been more elaborated upon in relation to the so-called functional state or neuroses which make up a good percentage of complaints heard by most practitioners. Sympathetic and vagus reactions are certainly involved in so-called functional states as hysteria, neuresthenia, etc., as suggested by the author. One cannot quite agree with the statement that in most cases possibly "suggestion" rather than the pharmaco-dynamic approach counts the most.

Medical students, medical writers and those interested i the historical will appreciate the final section "Introductio to History of Neurology." One rarely finds it in moder works. The data therein contained goes back to the earl centuries covering the middle ages and our own conten porary teachers both Continental and American.

The bibliography is very complete and one admires th author's judgment in quoting the pioneers, such as Dejerin Purves-Stewart, and other European masters. Those of u who have known them personally, appreciate all the mo the author's having reviewed them for us, to say nothin of our contemporaries in this country such as the wel known neurological groups in the New York medical cen ters.

This volume, though it does not include as many photo grpahs of patients as others, does not burden the read with long case histories and too technical, anatomical an pathological photographs easily available elsewhere. Th volume is compact with very readable print. The la edition of Wechsler on Neurology is welcomed by studen especially, as well as the practitioner and specialists in th field.

"*HOW LIFE IS HANDED ON.*" *By Cyril Bibby,* M.A M.SC., F.L.S., Senior Lecturer at the College of St. Mar and St. John, London; Sometime Scholar of Queen College, London; Author of "Sex Education: A Guide fo Parents, Teachers and Youth Leaders." *New York Emerson Books, Inc.* 1947. 159 pp. $2.

Reviewed by STANLEY B. WELD

Instead of drawing its parallel lessons only from the bird as some authors have done in the past, this book delve into animal and plant life in an effort to illustrate the proces of reproduciton. The publishers advertise "How Life Handed On" as "a book to be read by children and younge adolescents." It is doubtful if many children of averag mental development would be interested in perusing thes pages. One might better say, "A book to be read *to* chi dren, etc." In his attempt to delve into biology and suc problems as the declining birth rate, the writer has faile to visualize his reader. The result is a bit stilted; but th author is an Englishman and probably not too familiar wit the American child.

Illustrations abound in this volume, most of them satisfac tory, some not suited to the reader. Fewer illustrations o the halftone variety would improve the attractiveness bu increase the cost. "Good pictures are eloquent."

The appendix to this volume is one of its most valuabl assets. Here may be found a series of exercises adapted t each chapter which, like the laboratory experiment, wi add to the value of the text. Also there is a bibliograph of books on animal and plant life, a list of films to illustrat reproduction, and a reference list of uncommon words wit their meanings.

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ON BOECK'S SARCOIDS

I. SNAPPER, M.D., *New York City*

The Author. *Physician to the Mount Sinai Hospital, New York City*

IN THE second half of the 17th century De Le Boë-Sylvius, professor of medicine at the University of Leyden, found small nodules or "tubercula" at the autopsy of patients who died from consumption or phthisis. Since then the name tuberculosis has been used for the disease which formerly was designated as phthisis. In 1865, thanks to Virchow's investigation, the histology of these tubercles was revealed. These tubercles consist of a central giant cell of Langhans surrounded by numerous epitheloid cells, that is, swollen histiocytes and several outer layers of lymphocytes. In these tubercles a specific necrosis which is called a caseation necrosis easily develops. For a long time the diagnosis of tuberculosis depended upon the finding of such typical tubercles. However, after Villemin in 1865 showed that tuberculosis was an infectious disease, and after Robert Koch in 1882 demonstrated the presence of specific bacilli in these tubercles, the definition of tuberculosis has changed. Tuberculosis nowadays is a disease caused by the tubercle bacilus. This is especially important because granuloma tissue with a structure comparable to the tubercles found in real tuberculosis is found in other diseases, of which may be mentioned syphilis, leprosy and brucellosis.

There is a large group of diseases without a known etiology which have a certain resemblance to tuberculosis, especially because at histological examination tubercles with a structure similar to tubercles caused by tubercle bacilli are found. In 1889, Besnier described bluish red lesions on the tip of the nose, the cheeks, the lobes of the ears, the fingers and toes which grossly resembled lesions seen in chilblains. Examination of these areas with glass pressure on the lesions shows that they consist of brownish subcutaneous nodules. He, therefore, called the disease chilblain lupus or lupus pernio. The disease can easily be distinguished from real chilblains because lupus pernio occurs not only in the winter, but also in the summer months.

In 1899, Boeck from Norway described another lesion of the skin consisting of small reddish blue nodules which also on glass pressure could be seen to consist of brownish nodules in the subcutis. The lesions may itch, are often scaly and are sometimes very persistent. In most cases spontaneous regression occurs after which a brownish scale remains for some time. Boeck used the name "sarcoid" to designate these lesions because he considered that they might be closely related to the group of the ill defined pseudoleukemias. One year later, in 1900, he recognized that these lesions were not connected with the lymphomatous lesions which at the time were designated by the name pseudo-leukemia. He now stressed the similarity of the histology of the sarcoids with the lesions found in genuine lupus vulgaris. He, therefore, changed the name of sarcoid to "benign miliary lupoid." However, the latter name has never become popular and the lesion is still designated as Boeck's sarcoid. Boeck himself already recognized that these sarcoids were not limited to the skin. He also found them on the mucous membranes of the nose, the conjunctiva, the gums, the genitals and the bronchi, and also in the lymph nodes. In 1905, he concluded that the lesions must be caused by an uncommon and benign form of tubercle bacilus, because in one case inoculation of such lesion, situated on the nasal mucosa, caused a slowly developing tuberculosis in the guinea pig.

In 1914, Schaumann from Sweden proved that, as Boeck had already surmised, sarcoids of Boeck and lupus pernio were histologically the same

Presented at the 22nd Clinical Congress of the Connecticut State Medical Society, New Haven, September 18, 1947

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disease. In both diseases the fundamental lesion was a nodule consisting of accumulations of epithelial cells, in which often one or more giant cells were found. There is usually no necrosis, certainly no caseous necrosis, and therefore also no calcification. The little nodules may be characterized as "hard tubercles." Of great importance is the fact that around the Boeck's sarcoids no peritubercular inflammation is found. The collagen fibers of the tissues surrounding the Boeck's sarcoids are completely normal. There is a great tendency to scarring and sclerosis. The elastic fibers of the pre-existent tissue are completely destroyed by Boeck's sarcoids. This is generally found in any form of proliferative inflammation but much less in tuberculosis. Later, in 1941, Schaumann described that oval inclusion bodies with a double contour occur in the giant cells of the Boeck's sarcoids, the nature of which has not been determined until now. Sometimes these bodies seem to consist of concentric lamellae. Often they are calcified, occasionally they show positive iron staining. Asteroid inclusions which in the experience of some pathologists can be stained with elastica stains, are much rarer. Other investigators are of the opinion that these asteroids consist of lipoid material. Neither the inclusion bodies nor the asteroids are pathognomonic for Boeck's sarcoids.

The most important contribution of Schaumann was the elaboration of Boeck's original idea that sarcoids are not limited to the skin but that this disease is a true constitutional ailment. In many cases he described the presence of sarcoids in the skeleton, the lungs, spleen, liver, kidneys, thyroid, bone marrow, eyes, tonsils, pituitary gland, salivary glands, lacrimal glands, mammary glands. Later Longcope has pointed out that they are often localized in the heart. The presence of fever is frequent and other investigators have stressed that morphological and chemical changes of the blood commonly occur in these patients. Schaumann designated the clinical syndrome due to the visceral localization of Boeck's sarcoids as "benign lymphogranulomatosis." This name has not become popular because it reminded the European clinicians of Hodgkin's disease which was often called malignant lymphogranulomatosis and also of lymphopathia venerea for which the name veneral lymphogranuloma has been used. Thus, even today, the disease is usually called Boeck's sarcoidosis, sometimes Besnier-Boeck's disease even more completely Besnier-Boeck-Schaumann's disease. Swedish clinicians use the name Schaumann's disease, and in the German literature the name Mylius-Schürmann's disease is often found. In the course of years many review articles and monographs have tried to clarify this clinical entity.

As far as the clinical picture is concerned, the following data are of importance.

1. *Lymph nodes.* Lymph node swelling may be found anywhere in the body. The peripheral nodes are easily movable, non tender and there is no tendency to ulceration. As Boeck already pointed out, swelling of the cubital lymph nodes is frequently found. As far as the visceral lymph nodes are concerned, swelling of the nodes at the hilum of the lungs is remarkably often present. This swelling may lead to large hilar shadows on the x-ray pictures which often have been designated as "potato nodes."

2. *Lungs.* The localization in the lungs may give rise to different pictures. Sometimes the x-ray shows a generalized dissemination of the sarcoids which develop with preference in the periadventitial layers of the pulmonary capillaries, situated in the interalveolar septa. Such findings resemble the x-ray picture of miliary tuberculosis. It is true that even modern clinicians recognize that chronic miliary tuberculosis may occur. Nevertheless, in every case of "miliary tuberculosis" without fever and without serious clinical signs, the possibility of a pulmonary dissemination of sarcoids has to be considered. For many years the French clinicians have distinguished this syndrome as "granulie froide,"—"cold miliary tuberculosis." The roentgenologic lesions as found in disseminated sarcoids are usually slightly coarser than the small nodules found in miliary tuberculosis. Often in addition, a reticular pattern of the lung markings can be visualized. It should be added that similar x-ray pictures can be found in miliary carcinosis, in silicosis and anthracosis, in disseminated pneumonia, in Hand-Schüller-Christian's disease, and even in Hodgkin's disease.

The x-ray lesions of the localization of Boeck's sarcoids in the lungs may also be similar to infiltrating chronic tuberculosis. Occasionally, swelling of lymph nodes causes collapse of a larger part of one of the lobes which also can be demonstrated on the x-ray picture.

As mentioned above, sarcoids have a tendency to undergo fibrous degeneration. This may also happen

o the sarcoids situated in the interalveolar septa, esulting in a widespread interalveolar fibrosis with bliteration of the larger part of the interalveolar ulmonary capillaries. Under these circumstances, he resistance in the lesser circulation increases apidly, thus overburdening the right heart. The ulmonary ventilation rapidly deteriorates and such atients often die of cor pulmonale.

3. *Skeleton.* Boeck's sarcoids may be localized nywhere in the bone marrow, especially in the one marrow of phalanges of fingers and toes. esions in the long bones have been reported but re decidedly rare. The presence of Boeck's sarcoids in the fingers and toes gives rise to small, ound cystic areas which can easily be visualized by -ray. It has now been recognized that the disease hich was first described by Jüngling as multiple ystic tuberculous osteitis of the fingers is due to a ealization of Boeck's sarcoids. Occasionally the resence of Boeck's sarcoids in the bone marrow of he phalanges gives rise to widespread minute areas f bone resorption in the phalanges which appear in he x-ray as "lattice formations." Finally, at autopsy idespread dissemination of Boeck's sarcoids may e present in the skeleton although the x-rays show nly slight generalized decalcification.

4. *Eyes.* Practically all parts of the eyes may be ffected, the conjunctiva, the iris, the ciliary body. his explains the frequency of uveitis in these cases. s all lesions of Boeck's sarcoid, this uveitis has also tendency to heal. Unfortunately the subsequent earring often leads to secondary glaucoma and even o phthisis bulbi.

5. *Salivary glands.* The localization of Boeck's sarcoids in salivary glands may lead to a Mikulicz yndrome. Occasionally cases are encountered with ever, uveitis and swelling of the salivary glands. his syndrome which was often complicated by the resence of neurological signs was for many years lesignated as uveoparotid fever or Heerfordt's syndrome. It has now been proven that all cases of the atter syndrome are caused by dissemination of Boeck's sarcoids.

6. *Tonsils.* Although the frequent localization of Boeck's sarcoids in the tonsils has hardly any clinical mportance, it may have diagnostic value. The diagnosis of Boeck's sarcoids can only be made with certainty if a biopsy of the sarcoids in the skin or n one of the peripheral lymph nodes is possible. In ases where no lesions of skin or lymph nodes are resent, the diagnosis of Boeck's sarcoids may sometimes be verified by examination of tonsils removed by tonsillectomy. Comparable tonsillar lesions may also be found in tuberculosis.

7. *Endocrine organs.* Lesions in and around the pituitary gland have not infrequently led to diabetes insipidus in patients with Boeck's sarcoids. Involvement of the thyroid gland has also been reported.

8. *Heart.* Although the original communications did not mention the presence of Boeck's sarcoids of the heart muscle, it has since been established that clinical and electrocardiographic signs may frequently be found in patients with Boeck's sarcoids, caused by the localization of the sarcoids in the heart muscle. There is reason to believe that certain cases of the mysterious Fiedler's myocarditis are due to Boeck's sarcoids.

9. *Liver.* The introduction of the liver puncture has demonstrated how often the liver is involved in this disease. Boeck's sarcoids could be demonstrated by liver puncture in 11 of 14 patients and in another series in 28 of 32 patients. Therefore liver puncture has become an important procedure for the diagnosis of Boeck's sarcoidosis.

10. *Nervous system.* In the description of febris uveoparotidea Heerfordt already stressed the frequency of cerebrospinal nerve paralysis occurring in this syndrome. Usually the facial nerve is involved. However, paralysis of other cerebrospinal nerves has also been described in this syndrome. Since Heerfordt's disease is now known to be identical with Boeck's sarcoid, the connection between the latter disease and the central nervous system has become evident. Meningoencephalitis, the syndrome of Guillhain-Barré, choriatic movements and other localizations in brain and cerebellum have been recorded by many different authors. We also have observed epileptiform cramps. These complications of the central nervous system have often been fatal.

11. *Blood vessels.* Changes in the blood vessels have been described infrequently. Nevertheless, they probably are not uncommon, and are usually due to development of Boeck's sarcoids taking issue from the periadventitial cells of the blood vessels. Most of the lesions of Boeck's sarcoids involving the vascular system are, therefore, located in the adventitia of the blood vessels. Occasionally they break into the media and even into the intima. In the latter case granulomatous tissue may bulge into the lumen of the blood vessels.

12. *Kidneys.* Localizations of Boeck's sarcoids in the kidneys have been described occasionally but usually in the form of localized, nodular Boeck's granulomas found at the autopsy (Spencer and Warren, Hollister and Harrell). Generalized dissemination of Boeck's sarcoids through the kidney parenchyma leading to renal failure has been reported as a great rarity (Chanial, Staehelin). Like other clinicians we have observed on and off cases of Boeck's sarcoids which showed albuminuria and signs of impairment of kidney function. (Klinefelter and Salley). In such cases a dissemination of Boeck's sarcoids localized in the walls of the arterioles which supply the glomeruli may well have compromised the circulation in the glomerular loops. However, in such cases a concomitant glomerulonephritis can never be excluded without an autopsy.

The following *constitutional signs* often accompany the visceral localization of Boeck's sarcoids.

1. Fever.

2. Leukopenia, monocytosis and eosinophilia, occasionally thrombopenias.

3. Hyperproteinemia due to an increase of the globulin fraction. After healing of the sarcoidosis the blood proteins become normal again.

4. Recently the presence of slight or moderate hypercalcemia and of an increased phosphatase content of the serum has been stressed. The majority of these cases hypercalcemia can be explained by a generalized decalcification of the skeleton, due to the dissemination of the sarcoids through the bone marrow. In constrast to the common finding of decalcification Shüpbach and Wernly describe a patient with Boeck's sarcoidosis in whom not only hypercalcemia but also generalized calcinosis was found. This patient had at the same time signs of renal failure. The generalized calcinosis of this case was evidently caused by calcium metastasis which is apt to be seen in all patients who show simultaneously hypercalcemia and renal acidosis irrespective of the cause of the renal failure.

Several instances of the *familial occurrence* of sarcoidosis have been reported (Robinson and Hahn).

CLINICAL COURSE

Patients with generalized Boeck's sarcoids often have remarkably few complaints. They may live for many years without severe symptoms or signs and often the granulomas disappear without leaving too much scar tissue. In such cases the submiliar dissemination in the lungs or large infiltration-lik pulmonary shadows may vanish completely. Whe the sarcoids are localized in the eyes. dangerou after effects often set in; secondary glaucoma espe cially is a frequent complication of iridocycliti which occurs in Boeck's sarcoids. Death due t Boeck's sarcoids is usually caused by progressiv fibrosis of the lungs leading to right heart failur Granuloma formation in the myocardium or in th central system has been the cause of death in othe cases of Boeck's sarcoids.

Sometimes the condition of a patient with sarcoid osis deteriorates quickly, concomitant with the dis appearance of the widespread submiliary pulmonar dissemination of Boeck's sarcoids on serial roentgenc grams. It should be stressed that the radiologica signs of the dissemination of the sarcoids throug the lungs disappear either when the sarcoids ar absorbed or when they become fibrous in natur Even when fibrosis sets in, the lung fields whic were formerly studded with small lesions clear u and ultimately only exhibit a discreet reticular pat tern. It is easy to distinguish whether the disappear ance of the radiological dissemination is due t absorption of sarcoids or to fibrous degeneratior In the first case the pulmonary ventilation remain normal. However, as soon as pulmonary fibrosi develops the vital capacity measured with th respirometer diminishes progressively notwithstand ing the apparent improvement of the roentgenc grams.

Skin reaction. A skin reaction for the diagnosi of Boeck's sarcoid has been devised by Kvein The antigen is prepared from lymph nodes affecte by Boeck's sarcoids just like Frei's antigen is pre pared from the lymph nodes of a case of lympho pathia venerea. Two weeks after intracutaneou injection of this extract in a patient with Boeck disease, a papule develops which is followed by th formation of a crust and some necrosis. Biopsy c this lesion shows that a granuloma with the histo logic characteristics of Boeck's sarcoids has deve oped at the site of inoculation. More experience necessary before a conclusion can be made abou the specificity of this reaction.

Treatment. The treatment of this disease consis only of measures to improve the general conditio Administration of arsenic, vitamin B, vitamin C chaulmoogra oil and gold injections have bee advocated. Lately, the treatment with large dos

of vitamin D_2 has been recommended. Although the results evidently are not as spectacular as the rapid improvement obtained in lupus vulgaris, the vitamin D_2 treatment should certainly be tried in appropriate cases of Boeck's sarcoidosis.

It seems certain that roentgen treatment may cause shrinkage of large pulmonary lesions due to Boeck's sarcoids. Nevertheless, it seems hardly advisable to use x-ray treatment for this disease. As long as the lesions are fresh the pulmonary localizations of Boeck's sarcoids do not endanger life. In many cases the disease even does not cause serious symptoms or signs. The dangerous influence upon the pulmonary circulation only develops when scarring of the sarcoids sets in. In view of the tendency to fibrosis of organs under influence of roentgen treatment it seems reasonable to avoid roentgen rays as much as possible in the treatment of Boeck's sarcoids.

As far as the *etiology* of the disease is concerned, opinions are still divided. Not only Boeck but also Schaumann accepted the tuberculous etiology of this disease. Many modern clinicians agree with these two Scandinavian investigators.

The following points are always brought forward in favor of this opinion.

1. It is certain that the microscopic structure of the sarcoids vividly resembles the structure of tuberculous tubercles. One the other hand, necrosis and caseation are only exceptionally found in Boeck's sarcoids.

2. It has been emphasized that the development of active tuberculosis is not infrequent in patients with Boeck's sarcoids. This is especially the case in the United States where the negro race shows a great tendency to develop disseminated sarcoids. It cannot be denied that also among the white population of the United States and Europe, terminal tuberculosis is not an exceptional occurrence in patients with Boeck's sarcoids. In 33 autopsy cases of Boeck's sarcoidosis, 5 actually had died of progressive tuberculosis. In 8 other cases more or less active tuberculous lesions were found, in 7 others inactive tuberculosis was present. In 13 cases no signs of tuberculosis were found. However, in 3 of these 13 cases without tuberculous lesions, guinea pig inoculation proved the presence of tubercle bacilli in the diseased organs. On the other hand, terminal development of tuberculosis in Boeck's sarcoidosis can hardly be considered as proof of the tuberculous etiology of the disease, since in diabetes mellitus, in Hodgkin's disease, and in leprosy a terminal tuberculosis is not infrequent.

3. Injection of human tubercle bacilli into rats and of different strains of animal tubercle bacilli in other mammals causes the formation of tubercles similar to Boeck's sarcoids. The same can be obtained by the injection of dead tubercle bacilli, by the injection of extracts of living tubercle bacilli, and by the injection of non pathogenic myco-bacteria together with lipoids. Notwithstanding the histological similarity, these changes in experimental animals cannot be identified with Boeck's sarcoids in humans.

4. Occasional occurrence of erythema nodosum in patients with Boeck's sarcoids has been considered to be a sign of tuberculous invasion. However, this skin manifestation is nowadays only considered as an allergic reaction which can occur in many different diseases.

Thus none of the points raised in favor of the tuberculous etiology of Boeck's sarcoidosis seem irrefutable.

The following points are usually stressed as arguments in favor of a non tuberculous etiology of the disease.

a. Whereas in more than 80 per cent of the cases of lupus vulgaris the inoculation of guinea pigs gives a positive result, in Boeck's sarcoids which histologically closely resemble lupus, the inoculation into guinea pigs, rabbits, birds and even cold-blooded animals hardly ever gives rise to tuberculosis.

Kyrle in a famous observation found in a skin lesion, diagnosed as sarcoid of Boeck, many tubercle bacilli 10 days after the first manifestation of the skin lesion. After 21 days only few and after 36 days no tubercle bacilli could be demonstrated any more. Schaumann, however, is of the opinion that Kyrle's patient actually suffered from lupus and not from Boeck's sarcoids.

b. It has been pointed out that in leprosy, and in brucellosis granulomas are found which cannot be distinguished from Boeck's sarcoids. The presence of sarcoids with a tubercle-like structure is evidently not necessarily linked with the presence of tubercle bacilli.

c. It is remarkable that most of the patients with Boeck's sarcoids show negative skin reactions after injections of tuberculin. Even if one milligram of tuberculin is used for the intracutaneous reaction, the result is often negative.

In 26 of the 33 cases of autopsies of Besnier-Boeck's disease which are recorded in the literature, tuberculin reactions have been performed. In none of these cases has the tuberculin reaction been frankly and repeatedly positive. The Pirquet scarification reaction was only positive in a few cases. Even in these instances the reaction had been negative previously. In a few other cases the intracutaneous tuberculin reaction had been positive, but only in high doses. In 3 cases which at autopsy were complicated by tuberculosis the reaction had been negative consistently. In 6 other cases of Boeck's sarcoids complicated with tuberculosis the reactions were first negative, later weakly positive. Finally, a few patients first showed a weakly positive, later a completely negative reaction. Patients with Boeck's sarcoids are evidently hypoergic as far as tuberculin sensitivity is concerned.

Schaumann, on the other hand, insists that in cases of Boeck's sarcoids the development of tuberculosis leads to positive tuberculin reactions. When, in his patients, the tuberculosis progressed, the sarcoids healed and were transformed into scar tissue. A curative influence of tuberculosis on Boeck's sarcoids has since been reported repeatedly.

The following case report shows that in patients with sarcoidosis and tuberculosis, the tuberculin reactions may occasionally be positive.

In 1946, a 32 year old white female patient who had been followed at the Mount Sinai Hospital since 1928 was admitted. At the age of 14 she had been studied at the Hospital because of loss of weight, decreased appetite and polyuria of one year's duration. At the time she was thin and undernourished. Physical examination showed a few shotty nodes in the axilla. A diagnosis of diabetes mellitus was made and insulin prescribed. She remained well until 1938 except for episodes of infection associated with ketosis. At that time a roentgenogram of the lungs taken in the Clinic after an upper respiratory infection revealed the presence of enlarged hilar nodes. Swelling of the cervical nodes was also noted. A greatly enlarged, firm spleen was found, palpable four fingers below the costal margin with swelling of the cervical, axillary and inguinal lymph nodes. A lymph node biopsy was performed. The pathological diagnosis was either a non-caseating, epithelioid cell tuberculosis or Boeck's sarcoids. Parts of the node were injected into a guinea pig with a negative result. The Mantoux test (1: 10,000) at this time was positive for the first time in her life. Later, in 1938, a fawn-colored, discreetly raised rash appeared over the back and shoulders. This was diagnosed as sarcoidosis of the skin, which was confirmed by biopsy. Slight clubbing of the fingers and toes was present by the end of 1938. At this time the urine showed traces of albumin and many hyaline and granular casts. There was no azotemia and the blood pressure was normal. The total protein of the serum was 5.7 per cent (albumin 3.4 per cent, globulin 2.3 pe cent). The vital capacity was only 1,000 ccm. An x-ray o the chest showed studding of the lungs with innumerabl miliary deposits. The heart at this time was slightly en larged, but circulatory dynamics (venous pressure, circula tion time) were normal. The Mantoux test was again pos tive. A new lymph node biopsy showed the same pictur highly suggestive of Boeck's sarcoids. The guinea pi injection again was negative.

In 1940 she developed swelling of the ankles and fac associated with dyspnea and orthopnea. She was pallid an edematous. A gallop rhythm was present. Blood pressure wa 122/92. The spleen and liver were both easily palpable, fingers below the costal margin. There was shifting dulnes Clubbing had increased considerably. The skin lesions pre viously noted were no longer present. X-ray of the che showed considerable resolution of the miliary infiltration The heart was enlarged. The circulatory dynamics wer those of right sided congestive failure with a prolonged eth time and a high venous pressure. Congo-red test showe only 35 per cent retention in tissues. The hgb. was 128 pe cent with RBC 6.5 m., WBC 4,550, with eosinophiles per cent. Urine contained 2 + protein. Total serum protei 4.6 per cent (albumin 3 per cent, globulin 1.6 per cent) Cholesterol 310 mgms. per cent. She was treated with mer curial diuretics and ammonium chloride with good respons Her heart failure was interpreted as being due to pulmonar fibrosis and her urinary findings were explained as a Kim melstiehl-Wilson syndrome, that is, intracapillary glomeru losclerosis.

In 1941 she was again admitted in congestive failure wit dyspnea, orthopnea, anasarca and marked clubbing of fin gers and toes. At that time the edema did not disappea any more with mercupurine injections. Inconstant blowin systolic and diastolic murmurs were audible. The possibilit of rheumatic heart disease was postulated. Lymph node spleen and liver were enlarged as previously. The total bloo count had come down to normal.

During the next three years there were repeated admis sions for heart failure and for cutaneous infections, com plicating her diabetes. The blood pressure went up t 150/100, the B.U.N. to 33, the cholesterol to 440. The poly cythemia had changed to a normochromic anemia. Th serum albumin-globulin figures remained on the levels men tioned previously. In 1946, the B.U.N. was 33, the PSP 5 per cent. Diabetic cataracts had developed, resulting in com plete blindness. The Mantoux reaction (1: 10,000) was agai 3 + positive.

Her last admission was in August 1946 with complain of weakness, shortness of breath and anasarca. Mercuri diuretics had finally failed to produce a diuresis. Bilater cataracts were present and there was no reaction of th pupils to light. The cervical veins were markedly distende There were large nodes in the axilla. Fluid was present i the right chest. The heart was enlarged to both left an right. A gallop rhythm was present at the apex. A blowin diastolic murmur was heard best over the pulmonic are A diagnosis of rheumatic heart disease had been considere for many years. Now the possibility of a pulmonary insu ficiency was discussed. The liver was tender, smooth, pa pable three fingers below the costal margin. The firm splee

was felt four fingers below the costal margin. A moderate amount of ascites was present. The blood pressure was 95/120. The fingers were clubbed. Knee-jerks and ankle jerks were absent, and the vibration sense was diminished in the lower extremities.

The urine showed a specific gravity 1:020, 3 plus albumin, plus sugar. The sediment contained white cells, red cells, hyaline and granular casts. Hgb. 65 per cent, WBC 5,750 with slight shift to the left. Red count 3.3 million. Total protein 5.9, B.U.N. 17 mgm. per cent, calcium 9.2 mgms. per cent, phosphorus 3.9 mg per cent, cholesterol 257 mg. per cent. Thus the previous chemical findings of azotemia and of nephrosis had largely disappeared.

Patient ran a brief downhill course and died in right heart failure.

The autopsy showed widespread fibrosis of the lungs due to Boeck's sarcoids and a cor pulmonale. There was no rheumatic involvement of the heart, the enlarged paratracheal, hilar, peripancreatic, lumbar and iliac lymph nodes were studded with Boeck's sarcoids. In addition, there was a large lymph node, partly caseous, partly calcified. Even in this node no acid fast bacteria were found and the guinea pig inoculation was also negative. A slight scattering of calcified "tubercles" was present in liver and spleen.

In this patient in the course of 18 years the development of diabetes mellitus, Boeck's sarcoidosis with fibrosis of the lung and ensuing right heart failure, transient polycythemia, albuminuria, hypoproteinemia, renal failure due to intracapillary glomerulosclerosis could be followed. The course of events illustrates perhaps a few points of the relation existing between Boeck's sarcoids and tuberculosis. In this patient the Mantoux reaction performed with a tuberculin dilution of 1:10,000 was continuously strongly positive; notwithstanding the presence of widespread Boeck's sarcoids, the tuberculous lymph node situated near the trachea had led to a positive skin reaction. Therefore, at least in some cases of Boeck's sarcoids complicated by tuberculosis, the tuberculin skin reactions become positive.

Secondly, if Boeck's sarcoids were a form of tuberculosis and would contain tubercle bacilli, then in a diabetic individual a spread of this "tuberculous" infection could have been expected. However, in this patient the course of the Boeck's sarcoidosis was not at all modified by the diabetes. Patient died of pulmonary fibrosis just as would have been the case if she had suffered from Boeck's sarcoids only, without diabetes. Michelson has emphasized several important differences between the clinical course of tuberculosis and of Boeck's sarcoids. He points out that whereas, in general, a patient with tuberculosis only does well if he can enjoy sufficient rest, good food and careful supervision, Boeck's sarcoids usually disappear gradually even if the patient does not take such therapeutic measures. In war torn countries tuberculosis spreads like wildfire, but the incidence of Boeck's sarcoids does not change. The prognosis of a special case of tuberculosis depends greatly on the spread of the disease: if many organs are involved by tuberculosis the outlook is unfavorable. In sarcoidosis, nearly without exception, many organs are affected but nevertheless the outlook in such cases is not unfavorable. In Boeck's sarcoids laryngeal and ileocecal involvement is remarkably rare whereas larynx and intestine are locations of predilection for a tuberculosis spread.

All these clinical data so clearly presented by Michelson seem to indicate fundamental differences between the clinical course of tuberculosis and Boeck's sarcoids. The absence of an unfavorable influence of diabetes on the course of Boeck's sarcoids in our patient seems to fit in well with the clinical differences existing between the two diseases.

Thus the opinions are divided. Many clinicians (Schaumann, Reisner, Pinner, Dressler, Leitner) are convinced that Boeck's sarcoids are due to a form of tuberculosis. Others are of the opinion that Boeck's sarcoids represent an allergic reaction to a tuberculous focus. Finally, the clinicians who are impressed by the presence of sarcoid-like lesions in leprosy, brucellosis and other diseases (periarteritis nodosa) defend the opinion that Boeck's disease could well be an allergic reaction to other microorganisms or vira or even to lipoids derived from bacteria related to the tubercle bacillus, the lepra bacillus or the actinomyces.

SUMMARY

Disseminated Boeck's sarcoids give rise to a typical clinical syndrome which, for the present anyway, must be distinguished from active tuberculosis.

The distribution of the lesions is different from the findings in tuberculosis. There also seem to exist characteristic differences in the clinical features of both diseases. Remarkably often a hypo-ergic reaction towards tuberculin is found. Moderate monocytosis, eosinophilia, hyperglobulinemia and hypercalcemia frequently occur. Only 26 positive results of guinea pig inoculations with tissues of Boeck's sarcoids have been reported in the literature and in several of the positive cases the diagnosis seems doubtful. It is the general consensus that inoculations prove that viable tubercle bacilli are hardly ever, if ever, present in the sarcoids.

THE CLINICAL SIGNIFICANCE OF CHANGES IN SMALL INTESTINAL FUNCTION

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DURING the course of a gastro-intestinal x-ray examination the radiologist occasionally may notice what has been called a deficiency pattern of the small bowel. The term deficiency pattern was introduced some eight years ago because the responsible intestinal abnormality was first noted in sprue and other conditions associated with marked nutritional disorders. It is now known, however, that this pattern is found not only in nutritional deficiencies, but also under a variety of other circumstances. For this reason, the clinical significance of the deficiency pattern is now problematical: what is its pathogenesis? What diagnoses does it suggest? Can it be treated? Such questions will be considered in this paper, but our present state of knowledge does not permit more than partial answers.

The small intestine as demonstrated after a barium meal is evaluated on the basis of its caliber, the distribution of the meal within the intestinal loops, and the relief cast by the mucosal folds. Normally the intestinal lumen exhibits a slightly diminishing but otherwise even caliber from duodenum to cecum. Except where interrupted by peristaltic activity, the suspension of barium is distributed in a continuous column through a number of adjacent intestinal coils. The jejunum, when full, presents a sharp outline with many fine and evenly spaced serrations produced by circular mucosal folds (valvulae conniventes, folds of Kerkring); when empty, this organ exhibits a feathery reticulum imparted by residual flecks of barium trapped in the interstices of the contracted mucosa. The mucosal markings of the ileum are less striking, but its outlines are usually clear and well defined. Gas shadows are usually not observed in the small bowel of the normal adult. A final point of importance is the transit time, the time required for the barium meal to pass from stomach to cecum. Provided the stomach is emptying properly, the transit time gives some indication of intestinal motor function. Under normal conditions, the ileum, the cecum, and the ascending colon contain most of the barium meal five hours after its ingestion.[1]

The normal radiologic characteristics of the small intestine are distorted in the deficiency pattern. Instead of displaying an even caliber, the intestinal loops may be hypertonic and contracted, or hypotonic and dilated. The barium meal is distributed in uneven sausage-shaped masses separated by constricted loops of bowel containing little or no opaque material, an appearance referred to as segmentation. In some areas the barium suspension puddles in dilated segments of bowel. The mucosal markings become irregular, fuzzy, and less distinct throughout the small intestine. The serrations of the full jejunum are coarse and fewer in number, or they may disappear altogether. In the empty jejunum the residual barium is scattered irregularly in masses of varying size. Small intestinal loops may contain collections of gas. The transit time may be decreased or prolonged. At times, the over-all transit time is normal, but the barium meal is transported in irregular rushes interrupted by long inactive periods.

It is generally supposed that the deficiency pattern is produced either by edema of the intestinal wall, or by disorders in the motor function of the small bowel.[2] On theoretical grounds, edema could narrow the lumen and obliterate the normal mucosal markings. On the other hand, segmentation, mucosal changes, and deranged transit occur in conditions in which the presence of edema is extremely unlikely. Conversely, the edematous intes-

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ine does not necessarily manifest the deficiency pattern. For these reasons the alternative explanation appears more reasonable: that the deficiency pattern is caused by a deranged intestinal motor unction.[3] At times such functional disorders and edema may co-exist.

In 1933, Mackie[4] described dilated coils of ejunum and delayed passage of a barium meal n a patient with sprue. Soon thereafter other uthors[5,6,7,8,9] confirmed the fact that patients with prue, and also those with an advanced deficiency f the vitamin B-complex, exhibit the deficiency attern to a striking degree. It is therefore not surrising that the radiologic abnormalities were scribed to the lack of some factor in the vitamin -complex,[10,11,12] an impression strengthened by the ffectiveness of parenteral liver therapy, which rings about marked improvement in the x-ray ppearance of the small bowel except in those cases o long established that irreversible changes have aken place.[13,14,15,16] Many attempts were made to dentify the therapeutically active agent in vitamin -complex, but the search yielded equivocal results ntil the advent of folic acid. This substance appears o be as effective as liver extract in curing the deficiency pattern of patients with tropical sprue,[17] ut its efficacy in the non tropical varieties is variable.[18,19]

TABLE I

Pancreatic Insufficiency	
Icterus	
Parasitic Infestations	
Thyroid Disorders	
Acute Infections	
Ulcerative Colitis	
Ileitis (portions of small bowel not involved by inflammatory process)	
Gastro-enterostomy	
Entero-enterostomy	
Hypoproteinemia	In these states, local changes
Scleroderma	like edema probably are present

Conditions in which the deficiency pattern has been observed

TABLE II

Infants and children
Ingestion of Fatty or Nitrogenous Foods
Parasympathetic Inhibition
Allergy (?)
Emotional States
"Spontaneous" changes

Conditions which may manifest the deficiency pattern or which may derange normal motor function of the small intestine

There can be little doubt that deficiencies of folic acid and probably of other members of the vitamin B-complex can induce the deficiency pattern.[16,20] On the other hand, roentgenologists, as they became increasingly aware of this radiologic picture, recorded its appearance in a large variety of other conditions, many of which are listed in Tables I and II. Abnormal small intestinal motor activity occurring with the diseases listed in Table I, it may be argued, could be the result of inadequate nutriton since digestion and absorption might be affected by primary diseases of this type. The conditions listed in Table II, however, are related with difficulty to any nutritional deficiency.

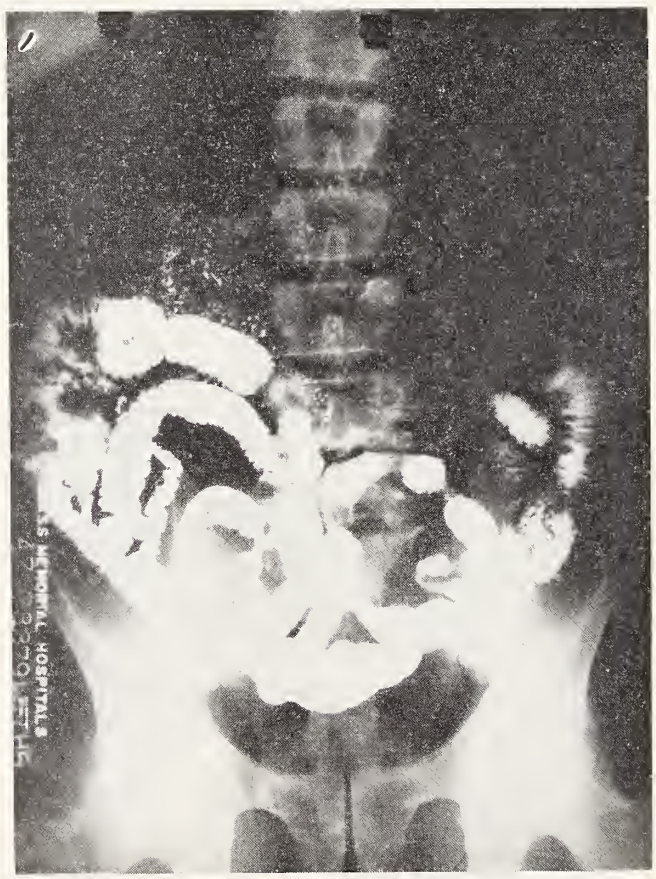


FIGURE 1

The normal small intestine. The barium meal is principally distributed in ileal loops

Noteworthy is the fact that the intestine of the normal infant exhibits the deficiency pattern after administration of the usual aqueous suspension of barium sulfate.[3] As the child grows, he gradually responds to the standard barium meal as the normal adult does.[21,22] Should the barium be suspended in nitrogenous or fatty food, particularly in milk, however, the young child's intestine again displays the deficiency pattern.[23] Milk, fat, or 50 per cent

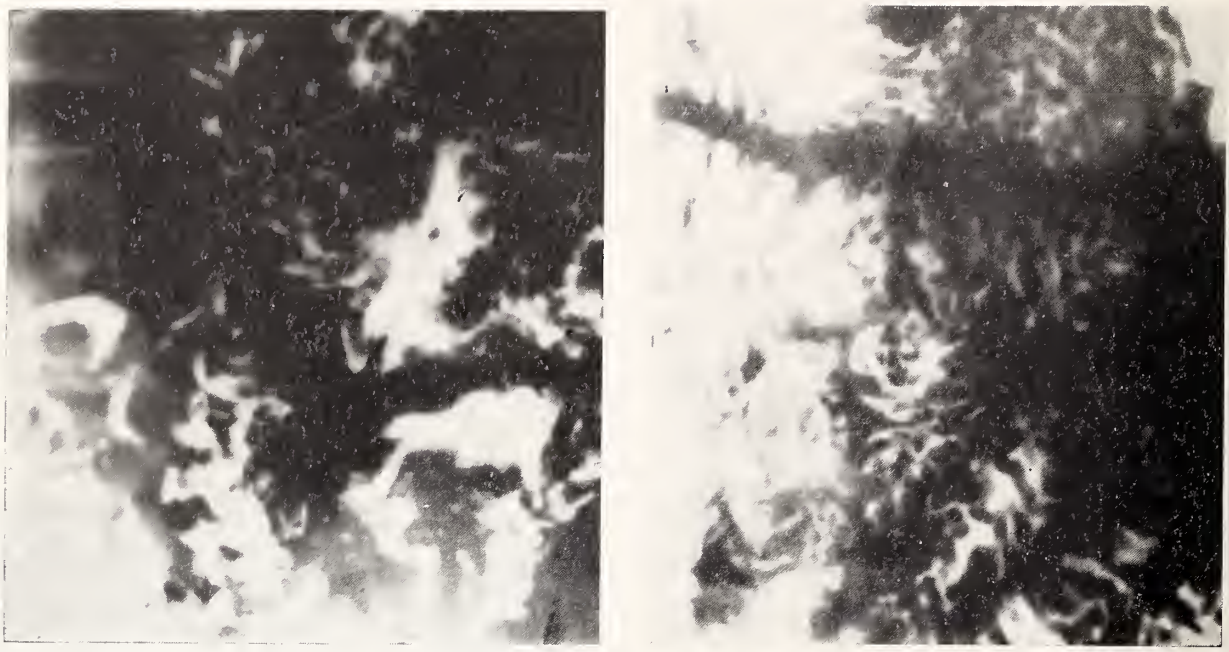


FIGURE 2

The normal feathery pattern of the jejunum appears on the right. On the left, the jejunal mucosal pattern is irregular and coarse in a patient apparently suffering from intermittent psychogenic diarrhea

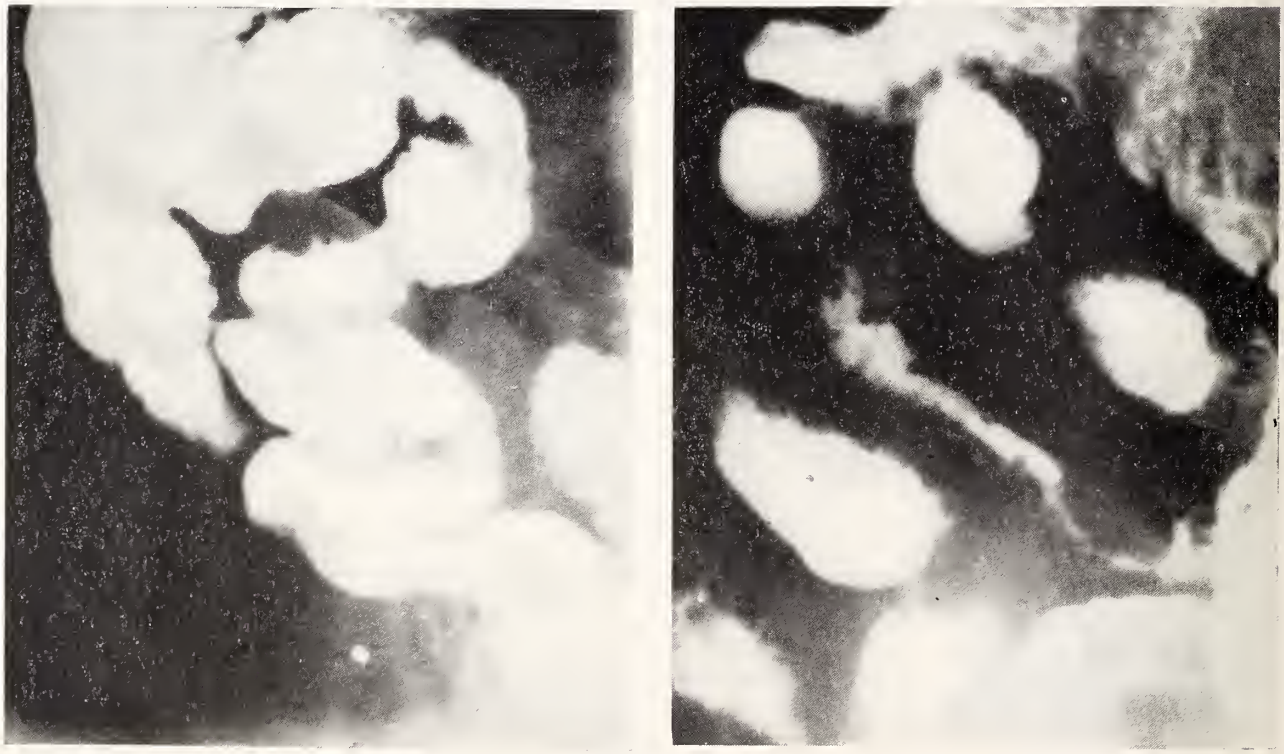


FIGURE 3

On the left, is a normal ileum displaying a rather even caliber except for peristaltic activity. On the right, ileal segmentation with irregular areas of spasm and segmentation are shown. This patient suffered from frequent and urgent bowel movements, but no organic disease could be discovered

lucose mixed with barium evokes a variable response in the adult. In some cases, nothing unusual occurs, but in others, definite motor and mucosal abnormalities take place.[24] Apparently the motor activity of the human small intestine responds non specifically to the ingestion of all substances during infancy, but subsequently develops the ability to react differently to various foods. This response to

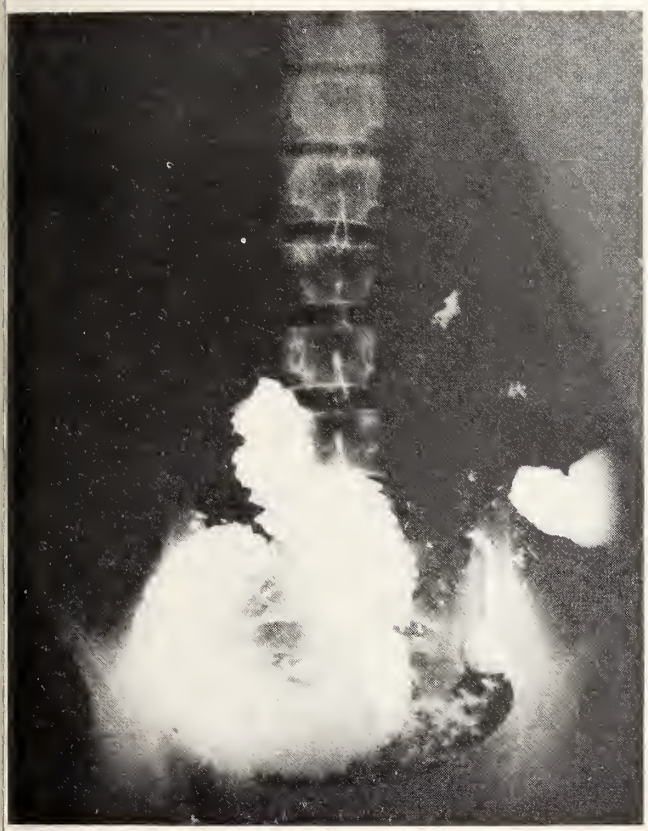


FIGURE 4
Marked puddling of barium meal in small intestinal loops. Patient suffered from sprue

pecific nutrients obviously does not account for he deficiency pattern seen in adults who are given n aqueous barium suspension, but it does show that he motor activity of the small bowel responds to ther stimuli than vitamin deficiencies. It also offers ome support for the hypothesis that the deficiency attern, irrespective of its causes, is a reversion to n infantile type of intestinal activity, perhaps ecause adult neuro-muscular mechanisms are damged or deranged.[3]

The participation of allergy in producing the leficiency pattern is problematical. Such a pattern, o be sure, may appear in allergic individuals if they re given milk mixed with the barium suspension,[25,26,27] but it has already been pointed out that a similar result may be expected in persons who suffer neither from allergy nor from gastro-intestinal symptoms.

Changes in the motor function of the small intestine probably occur on the basis of emotional states[8] and sometimes without apparent cause.[20] In rats, Golden[3] has shown that the small intestinal pattern changes under the influence of rage. The

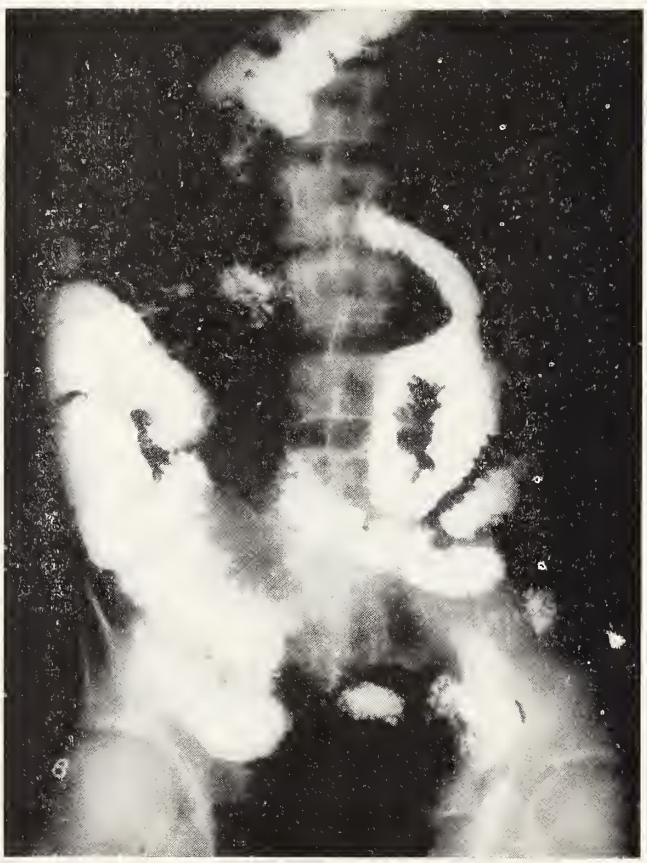


FIGURE 5
Ileum in patient with sprue. There is segmentation, coarsening of mucosal folds, and hazy flocculation of barium suspension (in pelvic loops of ileum)

same experiment in man presents certain difficulties and has not been tried. On the other hand, the effect of cerebral activity on intestinal function and the incidence of apparently spontaneous changes in motility have been observed in our laboratory by means of recording intestinal activity. This is accomplished by affixing the oral end of a Miller-Abbott tube to a kymographic device. If, as shown in Figure 6, the intestinal motor activity so recorded is affected by sleep or by unknown stimuli, it is possible that similar mechanisms may also alter the radiologic appearance of the small bowel.

The radiologic detection of a deficiency pattern, it appears from the above discussion, may signify a

nutritional deficiency, intestinal parasites, a derangement following gastro-enteric anastamosis, an emotional imbalance, or a number of other clinical conditions. Perhaps a common mechanism is operative in these disorders, but the occurrence of the deficiency pattern under such varied circumstances argues otherwise. Thus Golden[3] presents evidence that nutritional deficiencies primarily attack the intramural nervous plexuses of the gut, thereby occasioning diffuse changes in motility. In other conditions, however, the deficiency pattern could conceivably arise because of direct irritation of the intestinal musculature, because of humoral mechanisms, or because of stimuli carried to the bowel via its extrinsic nerves. Although little is known concerning the consequences of a disorder affecting the muscles or the intrinsic nerve plexuses of the bowel, the ability of the autonomic nervous system to affect motility is unchallenged. Sympathetic overactivity, for example, is held responsible for many of the manifestations of paralytic ileus. Removing much of the gut from the influence of sympathetic stimuli, as happens in lumbo-dorsal sympathectomy for hypertension, does not appear to affect intestinal motility significantly,[19] but vagal section, as done for treatment of peptic ulcer, may produce moderate hypomotility[19] and some features of the deficiency pattern. Neither stimulation nor ablation of the autonomic nerves has, however, been known to give a radiologic picture displaying all the characteristics of the deficiency pattern.

So far, the various clinical causes and the pathogenesis of the deficiency pattern have been discussed. One might also ask: do the motor abnormalities producing the deficiency pattern give rise to any characteristic syndrome, irrespective of the underlying causes? In patients with sprue, jaundice, parasitic infestation, advanced nutritional disorders, and infections, the clinical picture is essentially that of the primary disease. A type of patient remains, however, who may have a deficiency pattern on radiologic examination without obvious clinical cause. Lepore and Golden,[28] who believed that patients of this type represented cases of early vitamin B-complex deficiency, noticed a clinical syndrome consisting of weight loss, asthenia, anorexia, weakness, gaseous distention, "gas pains," and bowel disorders with constipation predominating. Such a syndrome, however, is common in many patients with functional disorders, whether psychogenic or of other origin. In our patients with the deficiency pattern, the clinical picture has been extremely variable, although about one-third of them complain of frequent unformed (but not watery) stools containing neither blood nor mucus. Frequently an urgent bowel movement is precipitated by the ingestion of a meal; at night, these patients are usually free of digestive complaints. Although proof is lacking, it is possible that the deficiency pattern and the abnormal bowel habits of these patients are causally related.

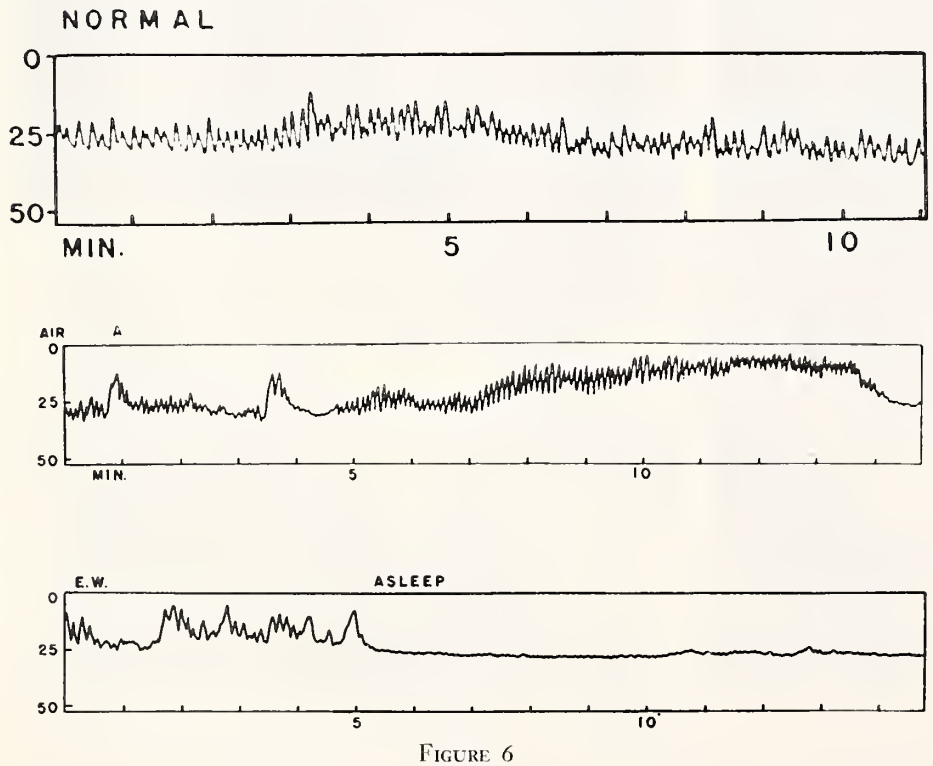


FIGURE 6

Kymographic records of motor activity of small intestine. Upper record is an average normal. Middle record shows spontaneous variations. Record at bottom shows change which may take place at onset of sleep

Treatment of patients manifesting the deficiency pattern obviously consists of attending to the primary disorder. If no primary disorder can be discerned, parenteral injections of crude (1 or 2 units per cc.) liver extract may be tried in doses of 2-3 cc. twice

weekly for 4-8 weeks. Such therapy is beneficial in some cases, but obviously does little to help the patient whose difficulty is principally psychogenic. Folic acid, which is helpful in sprue, does not benefit the patient with a deficiency pattern induced by other disorders.[19] As in any disturbance of intestinal motor function, antispasmodics and a bland but nutritionally well balanced diet may bring about symptomatic relief.

SUMMARY

Radiologic examination of the small intestine at times reveals a diffuse disorder involving the caliber, the mucosa, and the barium-transport of this organ. This x-ray appearance, though it has been given the name deficiency pattern, is found in a wide variety of clinical conditions. Its presence indicates that disorders such as sprue, vitamin B-complex deficiency, pancreatic disease, parasitic infestations, gastro-enteric anastamosis, and acute infections must be considered, but at times the deficiency pattern is the result of obscure causes, possibly psychogenic. Therapy consists of liver injections and symptomatic measures. Folic acid does not appear to help unless the patient suffers from sprue.

BIBLIOGRAPHY

. Golden, R.: Radiologic Examination of the Small Intestine, J. B. Lippincott Company, Philadelphia, 1945.

. Sussman, M. L., and Wachtel, E.: Factors concerned in the abnormal distribution of barium in the small bowel, Radiology 40:128, 1943.

. Golden, R.: Abnormalities of the small intestine in nutritional disturbances; some observations on their physiologic basis, Radiology 36:262, 1941.

. Mackie, T. T.: Nontropical sprue, M. Clin. N. Am. 7:165, 1933 (July).

. Snell, A. M., and Camp, J. D.: Chronic idiopathic steatorrhea. Roentgenologic observations, Arch. Int. Med. 3:615, 1934.

Pendergrass, E. P., and Comroe, B I: Roentgen study of gastro-intestinal tract in chronic idiopathic adult tetany, Am J. Roentgen. 33:647, 1935.

. Mackie, T. T., and Pound, R. E.: Changes in the gastrointestinal tract in deficiency states with special reference to the small intestine: a roentgenologic and chemical study of forty cases, J.A.M.A. 104:613, 1935.

. Golden, R.: The small intestine and diarrhea, Am. J. Roentgen. 36:892, 1936.

. Kantor, J. L.: The roentgen diagnosis of idiopathic steatorrhea and allied conditions. Practical value of the "moulage sign." Am. J. Roentgen. 41:758, 1939.

10. Mackie, T. T., and Mills, M. A.: Changes in the small intestine associated with deficiency diseases, Am. J. Dig. Dis. and Nutrition 7:480, 1940.

11. Elsom, K. O'S., Lewy, F. H., and Heublein, G. W.: Clinical studies of experimental human vitamin B-complex deficiency. Am. J. Med. Sci. 200:757, 1940.

12. Golden, R.: The small intestine in vitamin B deficiency, J.A.M.A. 117:913, 1941.

13. Miller, D. K., and Rhoads, C. P.: The effect of liver extract on the small intestine of patients with sprue, Am. J. Med. Sci. 191:453, 1936.

14. Miller, D. K., and Barker, W. H.: Clinical course and treatment of sprue, Arch. Int. Med. 60:385, 1937.

15. Snell, A. M.: Tropical and non-tropical sprue (chronic idiopathic steatorrhea): their probable interrelationship, Ann. Int. Med. 12:1632, 1939.

16. Learner, N., Stauffer, H. M., and Brown, C. L.: Small intestinal disorders in avitaminosis, Ann. Int. Med. 20:675, 1944.

17. Beguerie, R. L. H., and Spies, T. D.: Roentgenologic studies on the effect of synthetic folic acid on the gastrointestinal tract of patients with tropical sprue, Am. J. Roentgenol. 56:337, 1946.

18. Davidson, L. S. P., and Girdwood, R. H.: Folic acid as a therapeutic agent, Brit. Med. J. 1:587, 1947.

19. Ingelfinger, F. J.: Unpublished observations.

20. Ruffin, J. M., Baylin, G. J., and Cayer, D.: The clinical significance of alteration of the small intestine pattern as demonstrated by x-ray, Gastroenterology 4:289, 1945.

21. Macy, I. G., Reynolds, L., Souders, H. J., and Olson, M. B.: Normal variation in the gastrointestinal response of healthy children, Am. J. Roentgenol. 43:394, 1940.

22. Zwerling, H., and Nelson, W. E.: The roentgenologic pattern of the small intestine in infants and children, Radiology 40:277, 1943.

23. Reynolds, L., Macy, I. G., Hunscher, H., and Olson, M. B.: The gastrointestinal response of average, healthy children to test meals of barium in milk, cream, meat and carbohydrate media, Am. J. Roentgenol. 43:517, 1940.

24. Pendergrass, E. P., Ravdin, I. S., Johnston, C. G., and Hodes, P. J.: Studies of the small intestine. II. The effect of foods and various pathologic states on the gastric emptying and the small intestinal pattern, Radiology 26:651, 1936.

25. Fries, J. H., and Zizmor, J.: Roentgen studies of children with alimentary disturbances due to food allergy, Am. J. Dis. Child. 54:1239, 1937.

26. Cooke, R. A.: Protein derivatives as factors in allergy, Ann. Int. Med. 16:71, 1942.

27. Wing, W. M., and Smith, C. A.: Spontaneous and induced sensitivity to food stuffs: x-ray studies of the small intestine in man and guinea pigs, J. Allergy 14:56, 1942.

28. Lepore, M. J., and Golden, R.: A syndrome due to deficiency of the vitamin B complex, J.A.M.A. 117:918, 1941.

RESULTS OF TREATMENT OF CARCINOMA OF THE BODY OF THE UTERUS

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In the Norwalk Tumor Clinic malignancy of the body of the uterus was first seen in April 1935. From then to the spring of this year—a period of eleven years—a total of 46 cases, proved by biopsy, have accumulated. Four other cases were not included: two where the microscopic report was only suspicious and the patients have remained well; one patient who was admitted with carcinomatosis, the primary site never being established; and a fourth with metastases and ascites, being referred to this clinic for roentgen therapy after curettage and hysterectomy elsewhere.

Although a series of this size is really too small for statistical purposes, it still becomes necessary—if we are to learn from our past efforts—to divide it into three major parts. There are 39 carcinomas, 6 leiomyosarcomas, and one chorionepithelioma.

The carcinoma patients were all white and ranged in age from 39 to 86 with an average age of 63. Thirty-two individuals had been married. It was impossible to ascertain from the records whether 12 of these women had ever been pregnant. Six had not and 21 had delivered at least one child. One woman had delivered seventeen. The menopause was indeterminate in 8 patients. Of the remaining 31, 87 per cent had ceased menstruation an average of 16.1 years before the appearance of the earliest symptoms.

With only two exceptions, abnormal bleeding from the vagina was the predominant symptom. Other complaints included pain (4 cases), leukorrhea, weight loss, weakness, frequency, nocturia, malaise, etc., in occasional individuals. Also the bleeding was sometimes associated with a watery discharge. In the average patient the first symptom appeared 13 months before she visited the clinic. After 9 months she went to see a doctor and four months later she was either admitted to the hospital or seen in the Tumor Clinic. (However, information regarding the date of her first visit to the physician is not obtainable in 41 per cent of these records. The importance of completing thoughtfully the standard history forms, to which Dr. Simon referred, should be emphasized.) A family history—which had been taken in only 27 cases—was positive in 6 instances—or 2 per cent. Three patients had pre viously had mastectomy.

Since 64 per cent of the tumors in the grou have not been graded, suffice it to say that they ar all adenocarcinomas, with at least a third papillary A few were called adenoacanthoma and adenom malignum. Biopsy was usually an operating roor procedure.

It is interesting to note that three patients ha previously been treated with radium—for fibroid for endometrial hyperplasia, and for an unrecorde ailment. One had had x-ray therapy to the pelv and two had received injections of estrogen.

Unlike the cervix cases there has been no fixe policy for treatment of malignancies of the fundu Radium—or in earlier years, radon—was used in 31- or 80 per cent—of the cases. Seventy-seven per cer of these were treated by one man and the other cases by three different surgeons. X-ray therapy wa administered to 5 patients under the direction c that department. Surgery, however, which was use in 20 patients was performed by 10 different oper ators.

The usual procedure in applying a radio-activ substance was similar to that used in treatment c the cervix, except that the rubber tubing containin one, two, or three capsules of radium or its emana tion was introduced well into the uterine cavity. Th amount used varied between 50 and 75 milligram and was allowed to remain in place between 46 an 100 hours, delivering an average dosage of 360 milligram hours, although individual treatmen ranged from 2000 to 6000 milligram hours—or mill curie hours. Of the 14 treated by this method alon 5 had a single treatment. Two died within a yea the other three were apparently free of disease months, 8 months, and 3½ years later. One othe woman had six two-millicurie radon seeds implante in her cervix, a dose of 1600 mc. in addition to 55c millicurie hours from the intrauterine capsule. C the 6 who received two applications of radium, or is well after 6 months. All the other 5 were aliv after 3 years; two are still well after 9 years, th other three dying after 3, 3½ and 4 years. Th interval between treatments was from 2 months t

years. One patient, given three applications in two years totaling 9300 millicurie hours, lived 8½ years. Three patients received x-ray in addition to the intrauterine radium, two surviving only one year and one dying in the tenth year.

The most successful method in this clinic of treating carcinoma of the body of the uterus has been the insertion of radium followed in about three months by total hysterectomy and bilateral salpingo-oophorectomy. This procedure, carried out on 7 individuals has resulted in four survivals beyond five years and a fifth, two years. Two were lost at 3 and 4 years. Results were less satisfactory if the cervix was not removed, two patients still surviving at 1½ and 3 years, and two dying after 5 months and 2 years. A fifth woman, who also had an ovary left in the pelvis, died in 8 months. Exodus came after 3½ years to one patient, who had a total hysterectomy but only one ovary removed. In one case x-ray and surgery were combined; in another all three agents were used. Neither patient survived two years. Treatment was limited to surgery in 5 cases. Three are alive without evidence of disease at 1, 2, and 8 years, one is alive with disease after one year, and the fifth died after 9¾ years. Two women were beyond definitive treatment and a third, having had radium, was opened for hysterectomy but closed again as being inoperable. A metastasis to the lung was treated by x-ray in one individual, and two secondary lesions of the anterior vaginal wall each received two radon seeds of 2 millicuries.

While the definite establishment of a diagnosis is essential to optimum treatment, the clinic staff tries to approach the problem aggressively so as to waste a minimum of time before instituting therapy. In 58 per cent, specimen for biopsy was taken and treatment initiated during the same procedure. The average delay was six days. An aid to diagnosis, particularly of persistent tumor following some form of radiation, is the hysterogram, which was used 3 times on these patients, and in one instance was followed by rather severe infection.

In the group of 6 leiomyosarcomas, the youngest patient was 18 and the oldest 69, with only two having reached the menopause. Three were unmarried, and a history of pregnancy could only be found on one of the six charts. Pain (especially during menstruation), abdominal mass, and irregular vaginal bleeding are the symptoms described. All patients were treated surgically, two with the addition of x-ray later, and one with implantation of radium preoperatively. The "myoma" and both ovaries were removed in a case fatal 5 months later. Myomectomy followed by supravaginal hysterectomy and bilateral salpingo-oophorectomy has kept one woman alive 4½ years already. Another supravaginal hysterectomy with removal of only one ovary did not prevent pulmonary metastasis. X-ray therapy was given to the pelvis and chest and she is still alive after 1½ years. The other supravaginal case with ovary remaining has survived 3½ years and seems to be free of disease, whereas a total hysterectomy and bilateral oophorectomy only survived 8 months. The 18 year old patient also had this last procedure and is alive with persistent disease at the end of a year.

Along with 5 hydatidiform moles—treated no more radically than by curettage—one malignant chorioepithelioma was seen. This 33 year old white American developed trouble from her second pregnancy. The uterus was curetted twice in an attempt to establish the diagnosis. Hysterosalpingogram was done at the Womans Hospital in New York, where total hysterectomy was later done. The Ascheim-Zondek test has remained negative and tumor is palpable in the pelvis after two years.

The composite results then in all 46 malignant cases are 23.91 per cent alive 5 years or more and 28.26 per cent alive and apparently free of disease less than 5 years.

From the study of these small numbers, perhaps we can derive some benefit and formulate some constructive criticism. The lay public has been circularized heavily about fighting cancer. It is our job to see that no time is wasted between the first visit of the patient to his physician, and his first curative treatment. In battling a dynamic disease we must be aggressive in establishing a pathological diagnosis and pushing treatment through. The keeping of complete Tumor Clinic records will prod us to maintain our medical standards, and will enable the state organization to combine the material of many clinics. We can surmise that the more frequent association of adequate surgery with preliminary radium implantation might improve our results in treating adenocarcinoma of the corpus uteri, and that this disease usually occurs after the menopause, whereas leiomyosarcoma occurs in younger women. Treatment of latter disease in the clinic has not been satisfactory. One case of chorioepithelioma, suspected here, was proved elsewhere and apparently cured by total hysterectomy.

RADIATION THERAPY OF CARCINOMA OF THE CERVIX

Joseph P. Connolly, M.D., *Stamford*

In the field of radiation therapy the treatment of carcinoma of the cervix has become one of the most gratifying to the therapist. Many feel that this is the treatment of choice. To be effective, however, it must be carried out intensively at the first attempt as repeated incomplete treatments seldom control the malignancy. Irradiation as employed at the Norwalk Hospital is applied intensively with the purpose of effecting a cure or a control of the malignant condition over a long period of time.

The methods of radiation to carcinoma of the cervix consist of two integral parts:

1. The pre radium high voltage x-ray therapy.

2. The treatment of the local lesion by radium (post radiation may be required depending on residual malignacy).

The combination of x-ray and radium therapy should never be considered as competitive but as complementary to each other. They should never be employed alone as complete radiation treatment is the combination of both methods.

In order that appropriate treatment may be planned the patient is examined to determine the extent of the local lesion and the degree of extension to the parametria or to other organs.

A biopsy is taken for diagnostic purposes to determine the presence and histological type of cell from the lesion.

In the preparation of the patient for irradiation there are certain important features to be carefully considered:

1. A complete physical examination of the patient should be done to determine her general health. Her health must be maintained to achieve results. Patients in poor physical condition respond poorly.

2. Complete blood count. If the patient has had periodic hemorrhages or a severe episode of bleeding, transfusion may be necessary. Carcinomatous patients respond better if their blood picture is normal.

3. Vaginal hygiene:

Douches of saline, boric acid or sodium bicarbonate may be used to aid in reducing infection and as cleansing agents.

4. X-ray of chest should be done to rule out any pulmonary pathology.

5. Urinalyses and intravenous pyelogram:

This is of utmost importance not only to determine the stage of the disease but to note for any obstruction to the ureters or pathological change of the kidney.

6. Cystoscopic examination to note for any malignant spread and the condition of the bladder.

7. During the course of therapy the patient is instructed to take liberal amounts of fluid, adequate nourishment and to avoid constipation by the use of bland cathartics. Vitamin intake should be increased if there is a suspicion that there may be some vitamin deficiency present.

In the radiation treatment of carcinoma of the cervix a sufficient dose should be administered not only to the primary lesion but also to the parametrial tissues.

Radium itself can be relied upon to control the local carcinomatous lesion if properly applied. It must be remembered that the effectiveness of radium is greatly diminished 3-4 cms. from the site of application. As a result other therapy is used and this is where external radiation plays a leading part.

The amount of radiation that may be delivered is of course limited by the skin reaction, the body contour and the site of the malignancy.

The aim of external radiation is to give as homogeneous and lethal dose as possible to the parametrial tissues, lymphatics and nodes. The radiation will reduce secondary infection, shrink the growth itself control bleeding and attack the malignant cells within the pelvis.

There are no set rules in the treatment of all patients. In a Stage I carcinoma of the cervix in which the tumor is limited to the cervix, we can rely on two anterior and two posterior portals However, if there is an extension into the parametrial tissues, in addition to the above named portals two lateral fields should be included.

When there is a large cauliflower mass replacing the cervix a perineal port will be of great benefit.

The factors used in high voltage therapy are: 200 K. V. with 0.5 mm Cu and 1 mm Al. filter. H. V. L. is 0.95. The distance varies. We prefer to treat at the 80 cm distance as this will increase our depth dose to the mid pelvis. Of course with this distance it is necessary to take more time in delivering the necessary number of roentgens to the malignant tissue within the pelvis. We feel, however, that this extra time taken is necessary to achieve the best results in this type of cancer that will spread through the parametria.

The size of the portal will also vary with the size of the patient. The smaller the portal, the better the depth dose, less skin reaction and also less radiation sickness.

The total dosage we like to apply varies. It usually amounts to 2,000 to 2,500 r's in air to each portal. The daily dose is 250 r's to two portals.

As regards to intravaginal cone therapy as advocated by some therapists, we do not find it practical in most cases. Perhaps in a stage I carcinoma it may be of some value. It is difficult to attack the parametrial areas by this method. In our experience here we have difficulty because the patient complains of pain and discomfort on the insertion of the cone. Because of this discomfort the patient tends to move and as a result the x-rays are delivered to the wrong area. If one should check on the settings it will be noted that the cone has moved. It is also a time consuming procedure for accurate placement. Also, I believe that it produces severe local reactions which may interfere with the accurate placement of the radium.

Depending upon any residual malignancy following x-ray and radium therapy, a second course of radiation therapy may be given. This usually takes place 4-6 weeks following the removal of the radium. Care must be taken that the uterine canal is sounded to rule out pyometria or hematometra.

Complications that may arise during radiation therapy:

1. Radiation Sickness: We treat this by forcing fluids, proper bowel hygiene, fruit juices, small amounts of sedation and multivitamins. Thiamine hydrochloride, 100 mgs. intramuscularly, preferably before treatment is of great value.

2. Injury to skin and subcutaneous tissues:

At start of treatment we instruct the patient to apply cold cream to areas being treated. If an erythema or exudative type of dermatitis starts, Aquaphor is applied locally. If patient complains of pain over treated skin area Nupercaine ointment is used.

3. Injury to rectal or intestinal mucous membrane.

The patient may complain of tenesmus and this may be followed by diarrhea and abdominal pain.

The patient is placed on a bland diet followed by rectal instillations of olive oil or cod liver oil. Opiates may have to be used. If symptoms persist the treatment is modified or stopped.

4. Injury to bladder:

If care is not used in the proper settings for therapy, bladder injuries may occur. If cystitis occurs instillation of an ounce of cod liver oil is of great benefit.

5. Blood studies must be done at frequent intervals during the course of therapy to note any damage to the hematopoietic system. Transfusions of whole blood should be resorted to if necessary.

6. Menopausal symptoms may occur in those patients in whom the menopause was not reached prior to radiation therapy. This should be treated in the routine manner but no glandular therapy should be given.

PROGNOSIS

1. The general condition of the patient is important. It is noted that those individuals who are undernourished, run down, poor hygiene or poor economic status do not respond favorably to radiation.

2. Stage I and II have a favorable prognosis. Stages III and IV are none too favorable but therapy is helpful as a palliative measure.

3. Invasion or obstruction to the ureters or urinary tract by metastases is a grave prognostic sign.

4. If the patient has developed ulcerations of the rectum or vaginal fistula the prognosis is poor.

PENTOTHAL, NITROUS OXYGEN, CURARE ANESTHESIA

John Brody, M.D., *New Haven*

In 1945 I reported the details and results of fifty clinical administrations of anesthesia using curare in combination with sodium pentothal, nitrous oxide and oxygen. Almost every type of abdominal operation in which relaxation is essential was represented. The patients were unselected and the results showed considerable promise. Since then I have continued to make use of this type of balanced anesthesia. My intention has been fourfold: (1) to work out the most suitable technique for its clinical administration; (2) to establish its range of safety in competent hands; (3) to prove its ability to effect satisfactory relaxation of the abdominal musculature; and finally (4) to establish and evaluate its contraindications. At our hospital we have given this anesthesia in over 1,350 cases up to the present time. The anesthesia personnel consisted of three physician-anesthesists and four anesthesia nurses. Our experiences and conclusions with this method have been about the same and in this paper I wish to summarize only my own personal cases which total about 250. The following is the list of operations performed and the number of each: appendectomy—45; abdominal hysterectomy—63; cholecystectomy—66; other pelvic procedures like suspensions and ovarian cysts—23; gastric resections—5; transthoracic gastric resections and esophagectomies—2; nephrectomy—2; abdominal perineal resections—2; small bowel resection in the anastomosis—3; cesarean section—3; vaginal hysterectomy—3; exploratory laparotomy—6; thyroidectomy—4; hernia—7; revision of colostomy—5; laryngospasm—2, and then a small, miscellaneous group numbering 9. The youngest patient in my group was 7 years of age, and the oldest 73. The longest operation lasted about 3½ hours. The average dose of 2½ per cent sodium pentothal was 35 cc., and the average dose of curare was 110 units.

TECHNIQUE

Our technique has been kept simple. We believe that the fewer the mechanical gadgets, the more time and effort can be given to constant an continuous supervision of the anesthetized patien We have not tried the pentothal drip metho nor have we tried fixed mixtures of pentoth and curare which have been recently reporte The sodium pentothal is made up to a 2½ pe cent solution and administered with a 20 c luer-lok syringe. If no other solution, as saline plasma, or blood, is being given the simple two-wa adapter is used, otherwise the three-way adapte The curare is given through the same adapter tha carries the pentothal. It has been the general feel ing that these two agents should enter the bloo stream without mixing. This precaution has bee justified because of the potential danger of injectin particulate material into the blood stream. We kno now what the nature of the precipitate is and it fate on entering the blood. We have made no at tempt, except in our first dozen cases, to preven precipitation. No single recognizable untowar reaction has occurred. No reaction has ever bee reported by other anesthetists as far as we are abl to discover. This fact will have practical importanc for those of us that encounter the occasional pa tient with very poor veins. The patient is anesthet ized with sodium pentothal. As soon as conscious ness is lost the nitrous oxide and oxygen, two liter of each, are started using the semi-closed absorptio technique. Thereafter the pentothal is intermittentl injected in sufficient amount to keep the patien in the desired depth of anesthesia. The optimun time to start the injection of curare, we feel, de pends almost entirely on the speed of the surgeon For the fast surgeon the initial dose is given at th time of skin incision. By the time the curare ha reached its maximum effect the peritoneal cavity i open and exploration and packing off can be don easily. For the slower surgeon it becomes a matte of estimating when to start the curare. The initia dose of curare for the average adult is 60 to 8 units, that is, 3 to 4 cc. If there is some disturbin resistance of the abdominal musculature when th peritoneal cavity is opened, I quickly inject anothe

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10 units. This will produce the desired relaxation in about a minute. During the intraperitoneal portion of the operation intermittent doses of 20 units are given. The time interval between injections varies between 10 and 30 minutes, depending on the patient. No fixed rule can be laid down to cover all the cases. If respiratory depression as manifested by shallow breathing, inspiratory gasps, intercostal paralysis of apnea occurs, it usually follows the initial dose of curare. Because of the transitory effect of the curare in the body, this respiratory depression can be adequately handled easily and quickly by pressure on the breathing bag in rhythm with the patient's own breathing. It is, of course, essential that this manoeuver be done cautiously, and that the airway be kept completely unobstructed. Respiratory depression, if it occurs, lasts usually from a few seconds to several minutes. Adequate oxygenation must be maintained at all times. As in other types of anesthesia, proper attention to premedication is very important as it definitely influences the anesthesia, the operation, and perhaps also the postoperative period. I use morphine sulphate and atropine sulphate in the ratio of 25 to 1. The night before the operation a barbiturate is given but no barbiturates are given as premedication the morning of the operation. The dosage of these agents is determined from the preoperative evaluation of the reflex irritability or metabolic activity of the patient. The morphine and atropine are given hypodermically 1½ hours before the time of operation, ¾ of an hour for the intramuscular route and 10 minutes for the intravenous. About 50 of my cases have been done with d-tubocurarine chloride instead of intocostrin, both Squibb products. I was unable to discover any qualitative or quantitative difference in the effect produced. A finer precipitate results with the d-tubocurarine than with intocostrin.

SAFETY

There were no deaths in the operating room in this series, nor were there any deaths in the postoperative period that could be directly related to this type of anesthesia. As closely as could be determined with intermittent pulse readings, there were no irregularities of pulse, bradycardias or tachycardias, such as is frequently encountered with cyclopropane anesthesia. There were a large number of patients who exhibited an early fall in blood pressure. However, in only two of my own cases did the pressure fall to the level seen so frequently under spinal anesthesia. In every case the pressure returned to normal or safe levels in 5 to 15 minutes without the use of any vasopressor drug. A marked laryngospasm developed in some of our pentothal cases following induction. The immediate intravenous injection of 40 to 50 units of curare dramatically overcame this phenomenon in less than a minute. So dramatic was the effect of the curare on the laryngeal spasm that we now use this drug as initial treatment in cases that develop spasm under anesthesia. It has been used so effectively in cases undergoing exodontia that I am convinced of its efficacy. The problem of the various degrees of respiratory depression is largely under the control of the anesthetist. Overdosage with either agent or both, if not watched for constantly and quickly and adequately treated, may result in serious sequelae. In not a single case in the entire series was it necessary to treat a depression with prostigmine, coramine, picrotoxin, or adrenalin. The rational physiological approach in treatment is the prompt establishment of an unobstructed airway, adequate and effective oxygenation, and a normal respiratory exchange. This approach is the same in anesthesia given by whatever route when the respiratory efficiency is encroached upon. By such an approach the immediate depression due to the curare is very easily handled. There is a rather common complaint by surgeons and house officers about the long postoperative narcosis and depression in patients who have had an anesthetic with sodium pentothal. These individuals have often found it necessary to administer analeptic therapy to attempt to arouse the patients. This is a serious and annoying problem. What is the answer? It has been our consistent experience that the vast majority of our patients leave the operating table with an active lid or stimulation reflex. A large percentage of the cases are awake when they leave the operating room floor. A small percentage return to their room still anesthetized, but even in these cases the patients respond very soon afterward. Why the discrepancy in results? The administration of anesthesia, by whatever agent or technique, is as good or safe as the person handling it. Is ether safe and cyclopropane unsafe? Is cyclopropane safe and pentothal unsafe? The answer, I am sure, must be obvious to all. We do not recommend this or any other anesthesia method to anyone just with the courage to use it. We feel that this combination of agents is very safe in the hands of medical personnel well trained and grounded in all the pharmacological and physio-

logical problems related to anesthesia. There were 8 patients who developed hiccup during the operation. The incidence of this annoying phenomenon was not limited to upper abdominal surgery. No specific treatment was instituted as the hiccup was of short duration, except in one case where the patient hiccuped intermittently for a week following surgery. This latter was an intestinal operation.

RELAXATION

It has been demonstrated adequately by many anesthetists that curare combined with cyclopropane or ether can produce satisfactory abdominal relaxation. We have satisfied ourselves that this combination of agents also produces a degree of relaxation that is almost comparable to that seen in spinal anesthesia. Our surgeons concur in our opinion. It is true that to effect such relaxation it may be necessary to increase the curare dosage to the point where definite respiratory depression takes place. This is hardly the rule. Where such a depression occurs it is a simple matter to tide the patients over this temporary state by the simple and fundamental treatment mentioned earlier. When falls in blood pressure occur under spinal anesthesia, sympathomimetic drugs are used with almost universally good results. We treat our respiratory depressions if they occur. In my own small series I had only two patients in whom I wished I had resorted to a spinal anesthetic. Both were to have a hysterectomy and both weighed over 200 pounds. I felt that the abdominal musculature was relaxed but the combination of a huge omental apron, marked fat deposit in the side walls of the pelvis, and markedly dilated intestine made the surgeon's work most trying and time consuming. I think twice now about considering this type of patient for pentothal curare anesthesia. The surgeon would have been much happier had I used a spinal anesthetic in these cases, and for that matter so would I. Early in our work with this combination we employed it for all intestinal surgery. Subsequent experience in cases like abdominal perineal resections and iliocolectomies showed us that our combination did not do a completely satisfactory job. Again it failed to produce a contracted intestine which most surgeons desire for their intestinal work. We still employ these agents for gastric and transthoracic work, but have abandoned their use for the type of intestinal case just mentioned.

LIMITATIONS AND CONTRAINDICATIONS

The number of operations and patients who are unable to benefit from this type of anesthesia are very few. We voluntarily exclude the type of intestinal case mentioned above. We exclude children under 5 years of age. We question its use in the extremely obese individual. It has turned out to be an excellent technique for transthoracic surgery, as it is a simple matter to produce the apnea that precedes the initiation of controlled respiration. We have used this combination in the aged and debilitated patient, although in most of these patients the curare is not necessary and is not often used. I am sure that it is a common experience that a little anesthesia goes a long way in this type of individual anyway. Contrary to some of the early reports from the war theaters and from conclusions drawn from animal experimentation in bleeding and shock cases, we use this combination of agents for these cases with excellent results. I realize that the cases we get in the civilian hospitals do not parallel the war casualty cases, because the latter group may be in a much more severe shock and may have been neglected for many hours before surgery. I do not wish to recommend this technique for such cases as I have had no experience with them. Again, in the shock or bleeding cases very little anesthesia goes a long way and curare is not often necessary, or if used, only in very small doses.

SUMMARY AND CONCLUSIONS

We have administered over 1,350 anesthesias with sodium pentothal, nitrous oxide oxygen, and curare. I have critically conducted and followed up 250 of my own cases. We have used intocostrin and d-tubo-curarine chloride with no qualitative or quantative difference noted. No attempt has been made to prevent the mixing of the curare with the pentothal. We do not elect to use this technique for certain intestinal operations and in the very young patient. We hesitate to use it in the very obese. All kinds of risks have been done with this combination of agents. It is excellent in transthoracic work; it has been dramatic in its ability to overcome laryngospasm. The technique is a simple one and is safe in competent hands. Patients appreciate intravenous anesthesia and the surgeon is pleased with the abdominal relaxation that these agents afford him. The postoperative convalescence is good and the postoperative complications are at least as low as in the other types of anesthesia.

BILATERAL RENAL TUBERCULOSIS IN PREGNANCY

Harry R. Newman, M.D., and Herbert Levine, M.D., *New Haven*

The concomitant occurrence of renal tuberculosis and pregnancy is not often reported. The paucity of such reports, particularly in the American literature, is deplored in the reviews of Pugh[1,2] and the case presentation of Low and Coakley.[3] The former authority points out that many cases of pregnancy are interrupted for renal symptomatology in which the etiology goes undetermined, and that the increased physiological activity of pregnancy is likely to activate latent tuberculous foci in the kidneys.

A careful review of the literature reveals that of the cases of renal tuberculosis in pregnancy which have been reported, only 8 have been instances of bilateral renal involvement. In 1925 Werboff[4] reviewed the subject extensively and found only two prior reports of the disease in both kidneys. Dozsa[5] presents a series of 27 cases, in 6 of which the renal disease was bilateral. Both these authors stress the deleterious effects of each of these conditions on the other, and recommend early interruption of the pregnancy and conservative management of the tuberculous process in the kidneys.

The 8 cases, together with one reported by Naeslund[6] in which tubercle bacilli were found in the urine of both kidneys 10 years before, but not at the time of pregnancy, constitute the entire literature on the concomitant occurrence of bilateral renal tuberculosis and pregnancy. In view of the rarity of such cases, the following report is presented.

H. B. a twenty-two year old white housewife was admitted to Grace-New Haven Community Hospital on August 28, 1946. She had had urinary frequency accompanied by burning and smarting since December 1945. She stated that she felt the desire to urinate about twice an hour. The urine was normal in color at all times, except for one specimen passed in March which appeared pinkish. She had experienced no pain whatever in any other region and denied similar symptoms. Her last menstrual period had occurred around May 1, 1946, and she was apparently in the fourth month of pregnancy. She had had one child 3 years earlier without complications or urinary difficulties.

The family and environmental history revealed no known contact with tuberculosis. Past history was negative, except for the usual childhood diseases. Systemic review was negative for complaints indicative of pulmonary tuberculosis.

Physical examination revealed a well developed and nourished white female of 22 years who did not appear acutely or chronically ill. The chest was clear and resonant and no abnormalities of breath sounds or rales could be heard. The breasts were moderately enlarged and slightly tender. The uterus was enlarged to a point midway between the pubic symphysis and the umbilicus. The kidneys were not palpable and no tenderness could be elicited in the renal areas. The rest of the examination was entirely negative. Temperature, pulse, respirations were all within normal limits. Blood pressure was 110/62 in both arms.

Hemoglobin was 77 per cent by the Dare method, and red blood count was 3.81 million. White cell count was 14,900 with 80 per cent polymorphonuclears, 14 per cent small lymphocytes, 5 per cent large lymphocytes and 1 per cent eosinophiles; 2 per cent of the polymorphonuclears were immature forms. The urine was light yellow and cloudy in appearance, had a specific gravity of 1.012, contained a trace of albumen, no sugar, casts, many white cells and many red cells. The blood sugar was 95 mgm per cent, nonprotein nitrogen 25 mgm per cent, and plasma sodium chloride 594 mgm per cent. The erythrocyte sedimentation time was 60 minutes and the Kahn test was negative. Bacteriological examination of the bladder urine revealed the presence of Mycobacterium tuberculosis. Tuberculin skin test was negative in dilutions of 1-10,000 and 1-1,000.

X-ray of the chest was negative for evidence of tuberculosis. Intravenous and retrograde pyelograms revealed irregularity and dilation of the superior minor calyces of the right kidney pelvis.

Cystoscopy revealed the bladder mucosa to be moderately congested throughout. The ureteral orifices were catheterized without difficulty and specimens of urine from each kidney were carefully obtained. Intravenous indigo carmine tests were normal for both sides. The urine specimens both contained Mycobacterium tuberculosis. Specimens of urine from the bladder and both ureters were innoculated into guinea pigs, and autopsies on these animals revealed tuberculosis lesions which likewise contained the organisms.

The patient was seen by an obstetrical consultant who deemed interruption of the pregnancy unwise at this time. She was discharged to her home in another city on September 7, 1946, and aborted spontaneously within two weeks thereafter. She was admitted to a tuberculosis sanitarium in December 1946 with similar complaints and findings. Retrograde pyelograms at that institution revealed more marked involvement of the right kidney and some distortion of the left superior calyces. She was given streptomycin for two weeks in April 1947, receiving 2 grams per day in divided doses, and she is said to have improved symptomatically under this regimen. She was transferred to the surgical serv-

ice and a right nephrectomy performed on April 24, 1947 yielded a kidney which showed marked and extensive tuberculous involvement. Her postoperative course has been reported as uneventful.

SUMMARY

A case of bilateral renal tuberculosis and pregnancy, a rare combination of lesions, is presented. The scarcity of reports of this condition is stressed and the literature reviewed.

BIBLIOGRAPHY

1. Pugh, W. S., Ann. Surg., 86, 591 (1927).
2. Pugh, W. S., J. Urol., 35, 160 (1936)
3. Low, H. T., and Coakley, H. E., Urol. and Cut. Rev., 47, 13 (1943).
4. Werboff, S., Zeit, f. Urol., 19, 496 (1925).
5. Dozsa, E., Zeit. f. Urol. Chir., 25, 310 (1928)
6. Naeslund, J., Upsala Läkereförenings Förhandligar, 37, 243 (1932).

THE CARE OF CRIPPLED CHILDREN IN CONNECTICUT

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Since the nationwide establishment of programs for the care of crippled children modifications have occurred in both plans and underlying philosophy, Originally these programs were confined to orthopedic disorders, but now many other diseases are included. The programs in Connecticut and in certain other states actually provide for chronically ill children. The Connecticut plan, as now developed, illustrates the prevailing pattern.

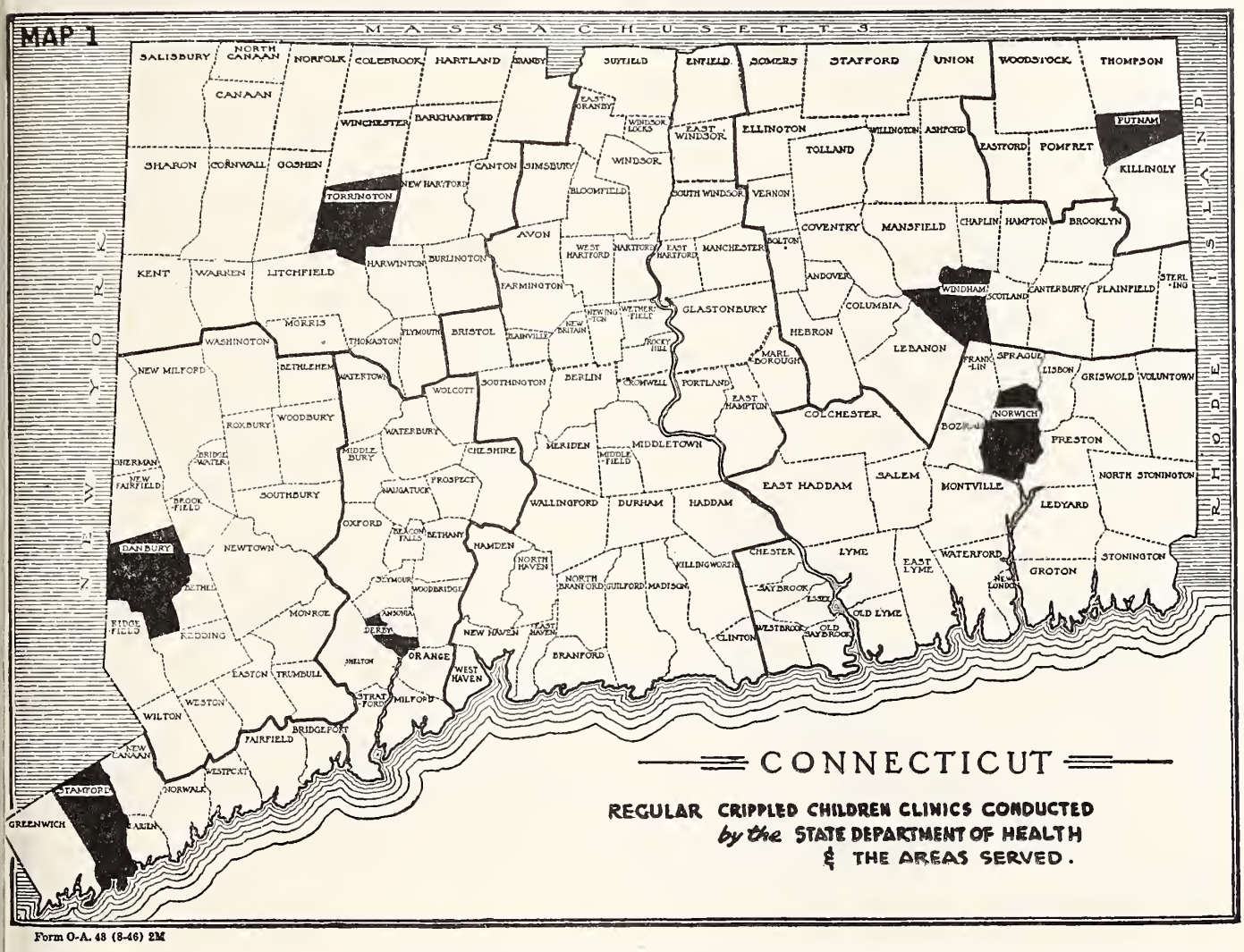
DEVELOPMENT OF SERVICES IN CONNECTICUT

1. *Medical care, medical social service and nursing, physical therapy and speech.* This paper deals only with medical care under public and private agencies. It recognizes that many crippled children are cared for by their own physicians.

a. State services for crippled children: Crippled children clinics conducted by the Connecticut State Department of Health are held in several areas of the state (see maps I and II). These clinics provide outpatient diagnostic and treatment services by personnel consisting of pediatricians and internists, orthopedic surgeons, otorhinolaryngologists, medical social workers, public health nurses, physical therapists, a speech teacher, and an audiometrist. Laboratory, x-ray and other diagnostic procedures are available at these clinics. Children are hospitalized when necessary for study and for operative procedures under specialists. Convalescent care is included in the program. Medical social services are provided in order that social conditions may be so modified as to promote the health of the individual and prevent adverse social factors from interfering with the physical care and emotional and mental development of the child.

Nursing, through public health nurses (visiting nurses and school nurses), provides follow-up in the child's home and school to see that medical recommendations are carried out and that health conditions within the home are at the best possible level. Physical therapy is given to children requiring muscle re-education and improvement in body mechanics. Speech training is provided for impediments due to organic defects of brain or speech apparatus.

b. The outpatient clinics of the Newington Home for Crippled Children provide services similar to those of the state crippled children clinics. The diagnostic categories eligible for treatment are restricted, in general, to the orthopedic and paralytic groups, whereas the state program covers other types of conditions. The Newington Home for Crippled Children is the only specialized institution in the state for the care of the orthopedically handicapped, providing hospital services and so-called home services to children who are not confined to bed but are ambulatory and can participate in group activities. These children include those who are



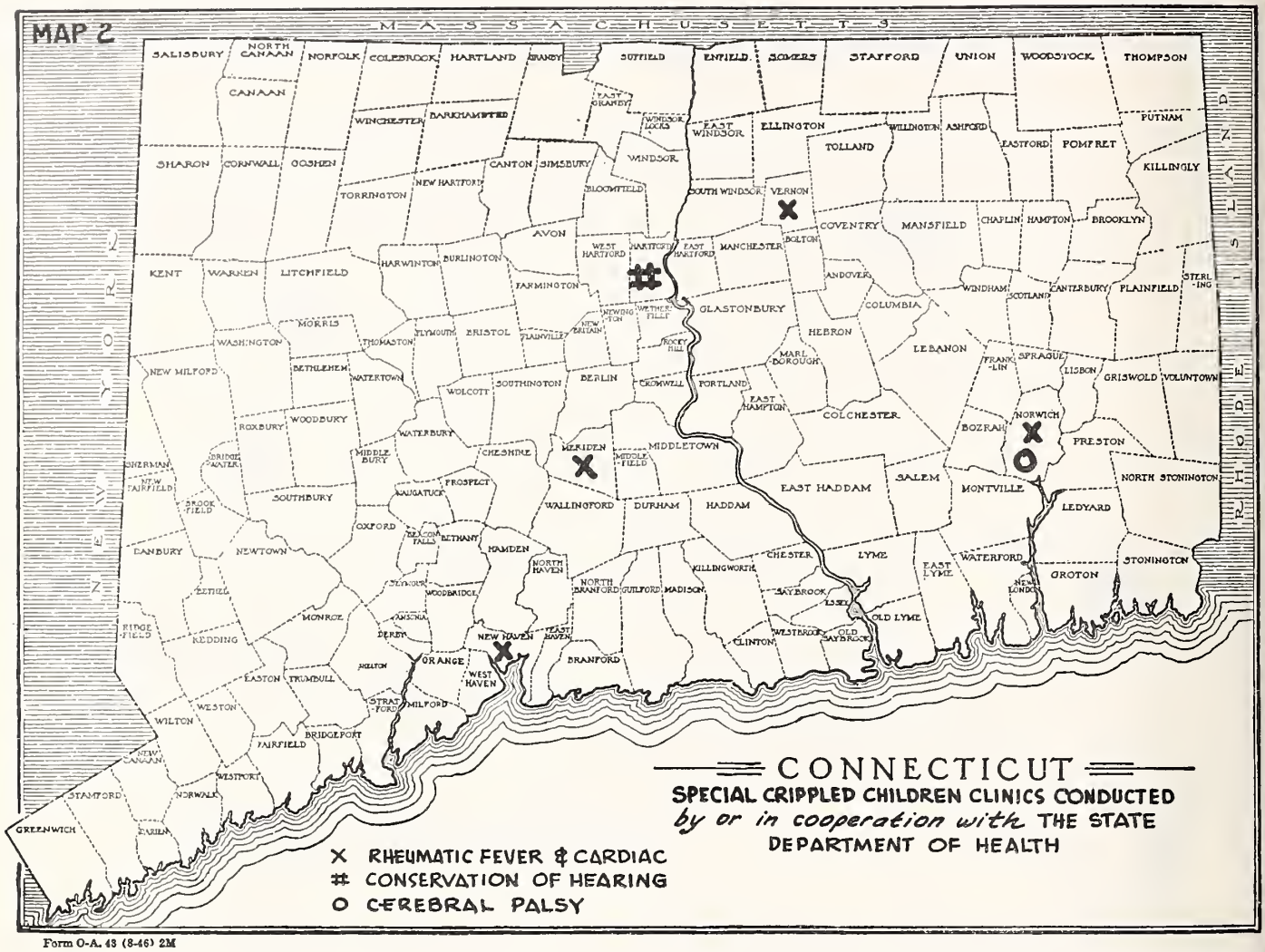
convalescing, having been discharged from the hospital section of the institution, and those who can receive special training, without being in the hospital section, such as muscle training. A program of education through the high school years is provided. Occupational therapy is now an established department.

c. The Physical Therapy Clinic of Bridgeport provides outpatient care for children in and around Bridgeport. Combined with this clinic is a workshop which is described below.

d. Other outpatient orthopedic clinics for children are located in the New Haven Hospital, Greenwich Hospital, Hartford Dispensary, The Chase Dispensary of the Waterbury Hospital, St. Mary's Hospital, Waterbury, St. Joseph's Hospital, Stamford and the McCook Memorial Hospital (limited to patients on Hartford public relief).

2. *Workshops.* Workshops for the physically handicapped fall into two objective groups. One group prepares a person to return to active life after a period of regulated work under conditions particularly suitable for him during the period of transition from convalescence to full activity. The work, itself, may be similar to that carried on during years of good health, or it may be in the nature of occupational therapy. The second group of workshops offers remunerative employment to persons so physically handicapped that they are unable to be employed under usual conditions. Both groups generally employ occupational therapy under supervision so that the work itself may be helpful in ameliorating the patient's handicap.

Workshops in Connecticut are conducted by the Connecticut Society for Crippled Children and Adults in Stamford, Bridgeport, New Haven and Hartford. In these workshops a program of physical rehabilitation also is carried on for persons sixteen years or over, particularly those with spinal cord injuries. This rehabilitation program is similar to



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that conducted in Army and Navy hospitals. Emphasis is placed upon muscle re-education, teaching the patient to care for his physical needs, teaching him how to sit, stand, walk with crutches and carry on the usual daily activities.

3. *Education.* It goes without saying that physically handicapped persons should have every educational advantage because many types of physical work may be closed to them. Since they will have to live in a normal environment for most of their lives, it is best that they attend regular classes and learn to make adjustments which their handicaps require. The regular school program may have to be modified in part. This special class is for those children who cannot take care of themselves well enough to share even a modified program. The special class should offer carefully designed equipment, well planned health care and curriculum adapted to individual needs. It is advisable to locate these classes in centers of populations where there are considerable numbers of handicapped children. Transportation should be provided so that the classes can serve rural and suburban communities as well as cities. There are several special classes in Connecticut for physically handicapped children but much remains to be done in this field. Children too handicapped to attend school receive home instruction under supervision of the local or state boards of education. The state law requires that a minimum of five hours per week for homebound children be provided. Institutionalization for educational purposes should be avoided except where the best care of the individual demands it. Special classes are to some extent being substituted for institutionalization and special classes should in turn give way to special programs and provisions within the regular classroom. Bedside teaching is frequently necessary for children who are hospitalized for long periods of time. This holds true for patients in general hospitals as well as those in hospitals for the chronically ill, such as the Newington Home for Crippled Children, Seaside Sanatorium and con-

valescent homes for children. Institutions caring for chronically ill children have teachers for both the individual child and the group.

Vocational guidance, vocational training and *job placement* for physically handicapped persons over the age of sixteen is a function of the Division of Rehabilitation of the Connecticut Department of Education. Under this program, persons sixteen years or over receive these services, provided the physical handicap permits them to be employable. In addition, this division provides physical restoration services (medical care) to persons sixteen years old and over who have physical handicaps which, if correctable within a reasonable period of time, will allow them to be employed.

4. *Other special services for the physically handicapped.*

a. Summer camps. Handicapped children who cannot take part in the activities of a camp for normal children require a special camp where activities are planned solely for them, the emphasis being on the needs of the individual camper rather than the group. Generally, summer camps are conducted purely for recreational reasons. In some camps, in addition to participating in the recreational program, crippled children may receive intensive treatment which may have been difficult to receive uninterruptedly at home. This treatment may consist of physical therapy for orthopedically crippled children, speech treatment for children with defective speech, regulation of diet and insulin for the child with diabetes, etc. In Connecticut there are no special camps for the physically handicapped. Ocassionally, however, a regular camp may modify its program for a short period of time to accommodate a small group of physically handicapped children. The New Britain Girl Scout Camp has a camp for physically handicapped children.

b. *Homebound.* This term refers to a person so restricted by physical disabilities that special activities under supervision must be centered in his own home. Schooling has been mentioned as being provided by the local board of state department of education. Special activities should also include recreation through teaching and supervision of craftwork. The craft articles produced may be sold through shops operated by local or statewide public or private organizations, such as the Connecticut Society for Crippled Children and Adults and the state board of education for the blind. These articles may be sold also through department stores and made according to contracts with commercial concerns. In general, the homebound production program is not remunerative, and the sponsoring organization makes up the deficit. However, the program is worthwhile because it gives the handicapped person a feeling of participation in family and economic life and helps to solve some of his social and economic needs. A craft program in a limited geographical area is provided by the Connecticut Society for Crippled Children and Adults. The homebound may require various types of treatment, such as physical therapy and occupational therapy, according to the recommendations of the attending physician. For necessary cases, physical therapy at home is provided by the state crippled children services; occupational therapy is provided to a limited extent by the Connecticut Society for Crippled Children and Adults.

5. *Permanent care.* There is a group, approximately 2 per cent of the orthopedically handicapped and paralytic group who, although having had extensive medical care, are still severely handicapped and ordinary care for them at home is difficult. For this group permanent or custodial care is necessary. The diseases of this group consist of spina bifida, cerebral palsy, the muscular dystrophies; occasionally other diseases, such as poliomyelitis and heart disease. So that their status quo may be maintained, these children require continuous medical care, expert nursing care, child guidance, schooling, occupational therapy, physical therapy and recreational therapy. There is no place in Connecticut where such children with normal or nearly normal mentality can be placed and receive the services enumerated.

THE CRIPPLED CHILDREN PROGRAM OF THE STATE DEPARTMENT OF HEALTH

The development of the program. In order that the development of crippled children services may be followed easier and the problems which arise in the care of children with such chronic diseases be more fully understood, a discussion of the state crippled children program follows. Table I shows both the changing administrative definition of a crippled child in accordance with the apparent needs, and how new services were added. It also shows the number of patients cared for each year and the annual percentage increase. From this table it can be seen that in 1939 the definition of a crippled child included the mentally defective child who could profit by treatment of his physical de-

fect to such an extent that he would be less of a burden upon his family. It is evident that the crippled children advisory committees which participated actively in the development of the program were socially minded. Speech services were added this year also in order that children with harelip, cleft palate and cerebral palsy might have

Table I

Definition of a Crippled Child, New Services Added, Case Load By Years—Connecticut State Crippled Children Services

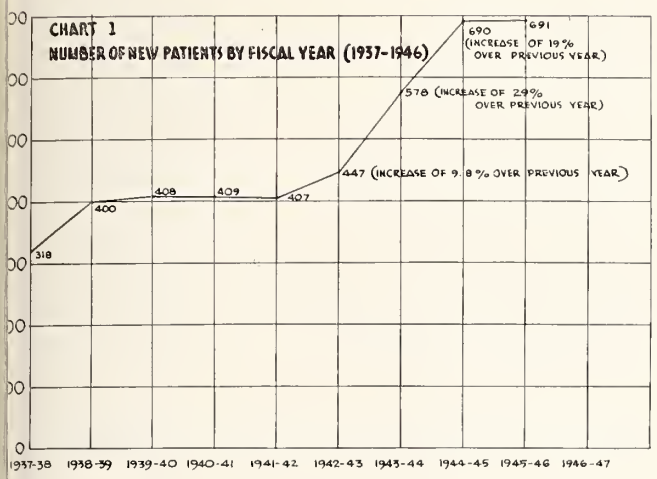
YEAR (FISCAL)	NO. OF PATIENTS CARED FOR (APPROXIMATED)	PERCENTAGE INCREASE	DEFINITION OF CRIPPLED CHILD AND NEW SERVICES ADDED
1937–38	318		Orthopedic, paralytic, spastic, rheumatic heart excluding children with low mentality
1938–39	667	110	No change
1939–40	965	44	Included mentally defective crippled children who would profit by treatment. Such services added on limited basis
1940–41	1121	16	Diaphragmatic hernia acceptable
1941–42	1367	22	March 1942 Putnam clinic started. May 1942 orthodontia services for children with harelip and cleft palate started. Children with bone tuberculosis accepted on referral from tuberculosis commission
YEAR (CALENDAR)	NO. OF PATIENTS CARED FOR (ACTUAL COUNT)	PERCENTAGE INCREASE	
1943	1486	9	Establishment of Meriden Cardiac Clinic. Cosmetically crippled disease acceptable; such as deformity of ears, birthmarks of face, etc., congenital and acquired hearing conditions added. Rheumatic fever activities intensified
1944	1768	19	Participation in Stamford Cardiac Clinic
1945	2129	20	First hard of hearing clinic established. Convulsive disorders, acute poliomyelitis, acute osteomyelitis and other "such crippling conditions added."
1946	2245	5	No change
1947	no data	no data	Establishment of the rheumatic fever and cardiac program in New Haven

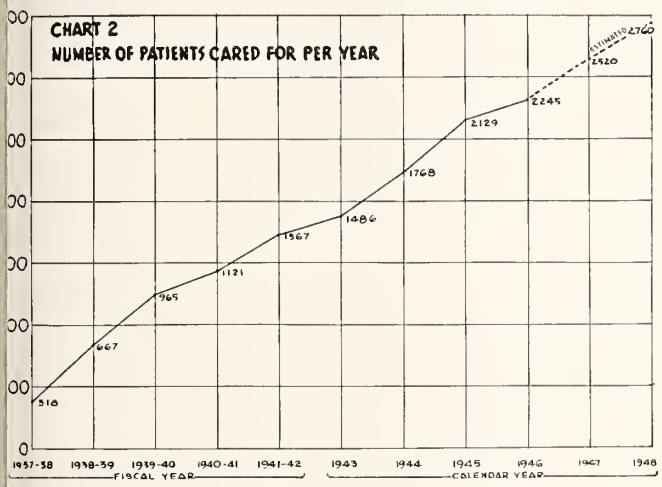
their defective speech improved. In 1941 a new clinic was started in Putnam to serve children in the northeastern part of the state, since it was found that many children did not attend the nearest clinic located at Norwich and Willimantic. It was soon apparent that after the clinic was opened many more children previously not under specialized care were referred by their physicians. In 1941 also, orthodontia services were developed for children with harelip and cleft palate. The state dental association took an active part in the technical aspects of this program. Here too the crippled children advisory committees were cognizant not only of the possible physical harm resulting from severe malocclusion but also of the effect it might have on emotional development and social acceptance through the cosmetic effect.

Children with tuberculosis are treated at the Seaside Sanatorium. In agreement with the sanatorium children discharged from the sanatorium and living at some distance from it are acceptable at the state crippled children clinics for follow-up care and for provision of such items as shoe adjustments, special shoes, etc.

In 1943, a cardiac clinic was established at the Meriden Hospital in close cooperation with the local medical society and other organizations interested in patients with heart disease, such as the visiting nurse association and social agencies. The medical care at this clinic is given entirely by local qualified specialists. The state department of health assists by providing a medical social worker, paying for the care of the children and paying clinic fees to the physicians, and advising on the administration of the program. In 1943, other crippling diseases which have a social significance became acceptable under the expanded definition, namely, deformities of the ears, birthmarks of the face and other similar deformities. For the first time children with defective hearing, due to congenital or acquired diseases, were acceptable under the program.

At the Stamford Hospital there has been a children's cardiac clinic for several years, sponsored not only by the physicians but by a lay group called the Stamford Cardiac Aid. During the war several of the physicians who were directly interested in the program served in the armed services. To prevent a discontinuance of the work, a physician of the state department of health conducted the clinic once weekly until the physicians formerly interested in the clinic returned from the armed forces. In





945, the first clinic for the hard of hearing child as established in Hartford. During this year, also, veral new crippling conditions became acceptable nder the program as indicated in the table.

In the summer of 1947 a rheumatic fever and rdiac program for New Haven was started with ie New Haven Health Department, the Pediatric epartment of Yale University School of Medicine id the State Department of Health cooperating. he clinics conducted under the program are held the New Haven Hospital and offer consultation children throughout the state with rheumatic ver, rheumatic heart disease and congenital heart isease (including "blue babies").

Chronic diseases of children require long time re. Many children are discharged from the serv- es each year, but because of the chronic nature f the conditions they must remain under care for any years. From Table I it will be seen that, ex- uding the percentage increase for 1938-39, there s been an average increase of 19.3 per cent in case load per year. Some patients are discharged after the initial visit, if nothing is wrong, or after a few months of treatment. Others have required care for longer periods, some since the opening of the first clinic in February 1938. Chart I shows the number of new patients referred by physicians. Table I and Chart II show the case load per year, that is, the actual number of children treated.

The above data show that over 2,245 children have been given treatment or service of one type or another during the year 1946. It is estimated, on the basis of previous experience that 2,520 children will be treated in 1947 and 2,760 in 1948.

Common Chronic Diseases Not Now Under Definition of Crippling. It has already been indicated how the definition of the crippled child has been modified to include new diagnostic categories. It might be well to consider briefly the field of chronic diseases in children to see what common diseases are not now included under the administrative definition of crippling. In Table II are listed common chronic diseases of childhood. In this table also are indicated the diseases now acceptable under the crippled children program. In general, the diagnoses acceptable under the state program fall into four main categories; namely, the orthopedic and paralytic; rheumatic fever, rheumatic heart disease and congenital heart disease; diseases requiring plastic surgery, such as burns and cleft palate; the hard of hearing.

The chronic conditions not acceptable under the crippled children program are indicated in Table II by blank spaces and are discussed according to the following groups:

Respiratory: None are eligible for care. It might be noted that the allergic conditions are easily handled in an outpatient service.

Gastro-intestinal: Celiac disease is not acceptable.

Skin: Skin conditions other than burns and unsightly hemangiomata are not acceptable under the program.

Circulatory, metabolic and glandular: The anemias are not eligible for care except when they occur as findings incidental to one of the chronic diseases eligible for treatment under the state program. Diabetes mellitus, hemophilia without orthopedic complications, cretinism, pituitary disease and obesity per se are not acceptable under the program. When obesity has a bearing upon the crippling condition, however, it is treated.

Table II

Common Chronic Diseases in Childhood

Common chronic diseases in childhood	Diseases now acceptable under the State Crippled Children program (clinics, hospitalization, etc.)
Respiratory	
Tuberculosis	
Empyema	
Lung abscess	
Bronchiectasis	
Allergic conditions—hay fever, asthma, allergic rhinitis	
Gastro-intestinal	
Harelip and cleft palate	x
Nutritional diseases	
Poisoning—lead, lye	x
Congenital anomalies requiring plastic repair, i.e., imperforate anus	x
Celiac disease	
Skin	
Burns	x
Fungus diseases	
Circulatory, Metabolic and Glandular	
Anemias	
Erythroblastic anemia	
Hemolytic anemia	
Sickle Cell anemia	
Secondary anemia	
Splenic anemia	
Heart disease—rheumatic, congenital	x
Rheumatic fever	x
Diabetes mellitus	
Hemophilia	If orthopedic complications
Pituitary diseases	
Obesity	
Neurological	
Hearing loss	x
Deafness	
Cerebral palsy	x
Epilepsy	x
Behavior and personality disorders	
Hydrocephalus	x
Mental deficiency	
Poliomyelitis	x
Spina bifida	x
Encephalitis—post-meningitis	x
Developmental and degenerative diseases of brain and spinal cord	x
Defective vision	
Cataract	
Squint	
Blindness	
Urological	
Nephritis	
Nephrosis	
Malformation of bladder, ureters, kidneys	x
Hypospadias	x
Tumors	
Orthopedic	
Deformities—congenital posttraumatic	x
Clubfoot	x
Dislocation of hip	x
Curvature of spine	x
Arthritis	x
Osteomyelitis	x
Postural abnormalities	x
Foot abnormalities	x
Muscular dystrophies and atrophies	x
Poliomyelitis	x
Bowlegs and knock-knees	x
Birth injuries	x

Outpatient Resources According to Diagnostic Groups

Something should be said about the geographica distribution of outpatient services available t crippled children from both the state crippled chil dren clinics and local hospital clinics.

Respiratory: Children with these diseases may b seen in the seven pediatric clinics in the general hos pitals. In only three hospitals and one dispensary no connected with the hospital are there special allergy clinics.

Gastrointestinal: Children with nutritional disease and celiac disease may be treated at the seven pedi atric clinics in the general hospitals as well as th pediatric clinics of two dispensaries.

Skin: Children with skin conditions may be see in the seven pediatric clinics. Only three hospital have special dermatological clinics.

Circulatory, metabolic and glandular: Childre with diseases listed here may be seen at the existing pediatric clinics. For children with heart disease an rheumatic fever there are, in addition, seven stat crippled children clinics, the state cardiac clinic held periodically at Rockville, the cardiac clinics at th Meriden Hospital, the Stamford Hospital, the New Haven Hospital, and at the Hartford Dispensary The recently established rheumatic fever and cardia program in New Haven serves the children in New Haven as well as offers consultation to childre throughout the state.

Neurological: Children with epilepsy may be see at the seven pediatric clinics located in general hos pitals in Connecticut. The New Haven Hospital ha in addition a neurological clinic for such children There is also a seizure clinic at Yale University where electroencephalography is available. Th 1945 General Assembly authorized the development of outpatient services for persons with epilepsy a

he Mansfield and Southbury Training Schools, but hese are not yet available.

Children with loss of hearing may be examined t the nose and throat clinics located in five of the eneral hospitals or at two dispensaries not located n hospitals. Although treatment at the usual nose nd throat clinic is of value in many cases of im- aired hearing, more in the way of diagnosis and reatment is needed for these patients than is usually vailable. In only one hospital clinic, and in one pecial hard of hearing clinic conducted by the state epartment of health are the necessary services com- lete or nearly complete. The state clinic is located t the Hartford Dispensary. This is staffed by a ediatrician, otorhinolaryngologist, an audiometrist, nedical social worker and public health nurse func- ioning as a unit. Hearing aids are provided. Through the cooperation of the Hartford Hearing League, a hearing aid consultation service is supplied o that the proper type of apparatus is fitted. Speech lasses are held at the League for those children vith defective speech and for those who need lip eading and acoustic training. At the New Haven Hospital outpatient department the needs of such hildren are recognized. They receive the pediatric nd otolaryngological examinations as well as the udiometric. Hearing aids must be provided through ocal resources but hearing aid consultation and peech services are not available. Thus, complete ervices for the hard of hearing child is limited to he geographical areas indicated by the location of he Hartford clinic.

Child guidance clinics through public and private esources are available throughout Connecticut. However, there are several areas which are not ufficiently covered, a lack recognized by the ureau of Mental Hygiene of the Connecticut State epartment of Health which has developed plans o extend the services to these areas when personnel nd funds become available.

Children suspected of being mentally defective ay be seen at the seven pediatric clinics in Con- ecticut. They are also referred to the bureau of ental hygiene as well as to the state crippled chil- ren clinics. Referral to the state crippled children linics is done for one of two reasons. A child may resent postural abnormalities which may be diag- osed as an orthopedic or paralytic condition. On horough detailed examination it is discovered that he basic defect is one of mental deficiency and evelopmental retardation. Children with mental deficiency already diagnosed by the referring physician are sent to the crippled children clinics for several reasons: for help in accurate determination of the mental level; for help in placing the child in an institution; for help in guiding the patient's care at home if he is not eligible for admission to an institution. Although these may not be appropriate functions of the crippled children program, the help to physicians, parents and children is given because other resources are lacking in many communities. Five outpatient clinics in hospitals are available to persons with visual defects. In addition, the board of education of the blind pays out of its funds for care by physicians in their offices.

Urological: Nephritis, nephrosis can be cared for on an outpatient basis in the seven pediatric clinics located in general hospitals.

Orthopedic: Most of the state is adequately serviced by state crippled children clinics or local orthopedic clinics. However, services for the paralytic and orthopedic group of children should be extended to one or two more areas of the state in order that the entire state might be more adequately covered.

PRESENT LACK IN FACILITIES

In summarizing the extent of the facilities for the treatment of common chronic diseases of children, the greatest deficiency apparently occurs in care for the following diseases: loss or defect of hearing; epilepsy; nephritis and nephrosis; respiratory diseases particularly the allergic conditions; gastrointestinal, nutritional and celiac diseases; skin disorders; circulatory, metabolic and glandular diseases such as the anemias, diabetes mellitus, hemophilia, pituitary diseases and obesity.

ADEQUACY OF PRESENT CRIPPLED CHILDREN SERVICES

Something might be said about the adequacy of services now available for children with chronic diseases, particularly the paralytic and orthopedic. There is much that can be done for cerebral palsy cases both from the institutional and outpatient aspects. It would be of value to have a cerebral palsy unit in an institution where children, particularly the more severely handicapped could have accurate evaluation and careful treatment in a suitable environment coupled with an educational program for the parents. There is need, too, for occupational therapy, including the newer rehabilitation procedures, for persons in institutions and those living at home and treated at crippled children clinics. For

children with cleft palate there is need for close integration of corrective dentistry and orthodontia so that the treatment can be quickly completed for best results. At the present time such children receive corrective dental work in one office and the orthodontia in the office of another dentist. Closer coordination in these fields would be of benefit to the patient.

In the care of patients with rheumatic fever and rheumatic heart disease, there is an unexplored field in the study of families of rheumatic children as a case finding procedure as well as to give other rheumatic members the benefit of follow-up services and prophylaxis. There is need for adequate corrective dentistry, especially for children with rheumatic fever to assist in maintaining optimum health and to remove and prevent possible foci of infection.

METHODS OF PROVIDING CARE NOT NOW AVAILABLE THROUGH PUBLIC OR PRIVATE AGENCIES

Physicians have the knowledge and skill to treat effectively most of the chronic diseases discussed, provided the necessary material facilities and personnel are made available. There is no doubt, therefore, that improvement in the completeness of care for the children can be accomplished. It is the extent of outpatient facilities for handling conditions which will be briefly discussed; though several methods of increasing such facilities are possible, two thoughts on the subject are proposed here.

The first is to include under the definition of the crippled child those chronic conditions which are not now included. Since the state crippled children clinics are located in various parts of the state, children with these newly included conditions will be able to avail themselves of clinic services more easily. The increasing number of children given service each year under the state crippled children program has been mentioned before. If new diagnostic cat gories were added, the number of children referre to the program by physicians would likely increas Additional clinics would be necessary; special clini would need to be developed to deal with diseas which require special diagnostic facilities, e.g., alle gic diseases. All this would mean that more wor would fall upon a program which has a centr administration. Additional staff would be needed i the State Department of Health in order to admi ister the program effectively and to maintain th present standards of care.

The second method would be to establish clini in district health departments, thereby providing decentralized type of administration with the sta staff acting in a consultative capacity. In the absen of district health units, clinics could be establishe at local general hospitals. The responsibility of co ducting clinics would be placed in the hands of th hospital administration. Provision should be made t maintain high standards of medical and relate services through highly qualified physicians, medic social workers, nurses, etc. This second method establishing local clinics would effect not only d centralization of services anticipated to result i greater efficiency, but would place services clos to the patient's town or residence. The latter is in portant since the more easily resources are availabl the more frequently they are used. General pediatri and surgical clinics could be established locally first and specialized clinics later as the need arises.

SUMMARY

Services for chronically ill children in Connect cut have been described. The deficiencies in th provision for their care have been noted an methods for rectifying these deficiencies have bee indicated.

A REVIEW OF OTOLARYNGOLOGY IN CONNECTICUT, PARTICULARLY IN NEW HAVEN COUNTY

M. Hemingway Merriman, M.D., *Waterbury*

The data for this address were gathered partly from official records, but chiefly from personal recollections of the older men in our specialty. According to the records in the State Department of Health, there were in the years between 1894 and 1904 only three doctors in the State registered as otolaryngologists; these were: Charles Upson, of Bristol; James Meek, of South Norwalk; and Angelo Cenciola, of Bridgeport.

Registered as practicing ophthalmology and otolaryngology were six: William Bacon of Hartford; Henry Miles of Bridgeport; Arthur N. Alling of New Haven; Maurice Rosen of Bridgeport; William B. Craig of Hartford; and Homer F. Miller of Bethel.

While these were the only men registered in the State Board of Health, there were many more practicing these specialities and these included Henry L. Swain of New Haven; Frederick N. Sperry of New Haven; Henry Miles of Bridgeport; J. C. Taylor of New London; Carl Munger of Waterbury.

The type of special training at that time in the early days of our specialty is interesting. A fairly typical example of training before the turn of the century is shown in the personal experience of Dr. J. C. Taylor, a well known otolaryngologist and ophthalmologist in New London who retired from active practice a short time ago.

He states: "I graduated from the University of Michigan Medical School in 1891. At the time I took up special training I was in general practice in North Manchester, near Hartford, and took the time at intervals as I could arrange it and still keep a line on my practice and derive some income therefrom. I began in 1894 going to New York School of Medicine which gave special courses from six weeks to three months. I took a 3-months' course under Dr. Oppenheimer, and some operative work on the cadaver. The following year, 1895, I took out a 3-months' clinical attendance permit at the New York Eye and Ear Infirmary on East 20th Street, and also some operative courses under Dr. Spafford. The next year, the winter of 1895 and 1896, I had the same kind of a clinical permit at the Knapp Ophthalmic and Aural Institute on East 12th Street, returning to North Manchester for week-ends, but sometimes staying in New York. I also had some operative work under Dr. Born and Dr. Toeplitz, most of it on pig's eyes and on the cadaver. Later I also took considerable evening work at intervals as I could get the opportunity at the New York Polyclinic Hospital. I had no internship or residency as is now the practice, as it was very hard to get the opportunity for a residency at that time. I realize that even then some men had much more extensive preparation, but many had less, and the specialties had so much less to learn than now, since the methods of both diagnosis and treatment were rather crude as compared with the present."

The first special courses in Connecticut were given at the Yale University School of Medicine starting in 1876, when William H. Carmalt, afterward known throughout the State as an eminent general surgeon, was appointed the first Professor of Otolaryngology and Ophthalmology. He served as such until 1881, at which time he became Professor of the Principals and Practice of General Surgery, and served until 1907. To us now it seems a rather odd jump from otolaryngology to general surgery. In the year 1895 Henry L. Swain was appointed a lecturer on the ear, nose and throat, and two years later was appointed a Professor of Otolaryngology, and served until 1915. He was succeeded by Frederick N. Sperry, who served as Clinical Professor of Otolaryngology from 1915 to 1942. Dr. Sperry was succeeded by Norton Canfield who is serving at the present time.

Address of the Retiring President—163rd Annual Meeting New Haven County Medical Association—New Haven, April 4, 1947.

So far as I know, the first physician to practice otolaryngology not combined with ophthalmology in New Haven County was Dr. Carl E. Munger of Waterbury. Dr. Munger graduated from Yale in 1880, and from the College of Physicians and Surgeons at Columbia University in 1883. He practiced general medicine for a few years and then, in order to equip himself properly, went abroad. This was the first of many sea trips during his lifetime. He made two trips around the world and crossed the Atlantic over 30 times. He studied in Munich, Vienna, and Berlin; settled in Waterbury in 1892, and was appointed a specialist on the Ear, Nose and Throat Service of the Waterbury Hospital. He also was on the staff of the Manhattan Eye, Ear and Throat Hospital in New York, and for many years spent one day a week at that hospital, leaving Waterbury on the 8:00 A. M. train and returning home at 7:00 P. M. for his evening office hours. In 1936 he died on board ship while returning from England.

Dr. Munger, with whom I was associated for several years until his retirement in 1932, often told me that in his early days a tonsillectomy was considered a major operation and that he usually had to persuade not only the family but often the family doctor that the operation was necessary. About the only indication for tonsillectomy at that time was recurrent tonsillitis, peritonsillar abscess, or great hypertrophy of the tonsils and adenoids. Their role as a focus of infection responsible for endocarditis, rheumatic fever, etc., was not generally recognized.

Dr. Sperry tells me that the wave of tonsillectomy did not come in until about 1910, and, as he expresses it, "I rode in on the crest of the wave."

I quote an extract from an interesting letter of E. Terry Smith of Hartford:

"The early days of otolaryngology in New Haven County might almost be the biography of Dr. Henry L. Swain. He trained in Leipzig and came back to this country, bringing with him a microscope, a number of stains for the few bacteria that were known in those days, and also a Kilian bronchoscope. For many years Dr. Swain was the only one who did the mastoid operation in New Haven. He did the first bronchoscopy in Connecticut, and for a long time was the only man here who knew anything about it. He was the earliest member in Connecticut of that august and exclusive organization, The American Laryngological Association, which limits its membership to 100 throughout the cou try. He was elected a member in 1879 and served president in 1900. Dr. Sperry of New Haven w the other pioneer. He was the first to practice to enucleation of tonsils in Connecticut."

Among the early writings in Connecticut relati to otolaryngology, I found the most interesting "Treatise on the Common Cold and Catarrh writen in 1830 by Lemuel Hopkins of Hartford. D Hopkins was a man of keen observation, and wh I finished the treatise I came to the conclusion tha more than 100 years ago, he perhaps knew mo about the fundamental conditions causing the co mon cold to develop based on changes in bod temperature than is generally recognized at t present time. The forms of treatment also attracte me: for example, the suggestion that if a man wh had a cold went on a hunting trip in the woods an slept on the ground with his feet toward the fir at the end of the week the symptoms would usuall have disappeared or else! This treatise is preserve in the archives of the Medical Library in Hartfor It is written in long-hand and is brown with age.

Another interesting book was written at a muc later date by Ernest Caulfield, also of Hartfor entitled "The True History of the Terrib Epidemic Vulgarly Called 'Throat Distempe Which Occurred in His Majesty's New Englan Colonies Between the Years 1735 and 1740." Th describes the first great epidemic of diphtheria i the New England colonies. Before 1900 diphther had been rampant in New England for over 15 years, and records in New York City show a mo tality from 100 to 350 per year for each hundre thousand inhabitants; this means a city of the prese size of Waterbury could expect a mortality of som thing over 350 in epidemic years—about one deat a day.

The first real contribution to lessen this mortalit was the development of the intubation tube b Thomas O'Dwyer of New York in 1875. D O'Dwyer deserves more than passing mention. H was an attending physician at the New York Orpha Hospital, was very quiet, religious, and studiou Epidemics among the orphans sometimes caused th death of half the children infected—usually fro suffocation. For 14 years Dr. O'Dwyer worked in small workroom in the basement to find some mea of giving these children air when the larynx w obstructed. The final result was the intubation tub

n various sizes with the intubator and extubator xactly as we have it now. In spite of opposition at rst, it was found that the mortality was two-thirds ss in children who intubated than in those who ere tracheotomized, and resulted in the saving of any thousands of lives before the general use of ntitoxin. His was America's great contribution to he relief in laryngeal diphtheria. We find that racheotomy was usually done by the general surgeon except in the large centers, presumably because ney had more experience in the surgery of the neck han the laryngologists. Dr. Sperry tells me that this as true in New Haven and Dr. Taylor says the me thing was the practice in New London. Intubation, however, was usually performed by laryngologists who had some special training in this rocedure.

In 1883 Klebs and Loeffler definitely identified the iphtheria bacillus and demonstrated that cultures om diphtheritic throats could establish a definite iagnosis. In 1890 Behring discovered that the serum f horses immunized against diphtheria by repeated erilized cultures conferred protection upon the orses. In 1894 it was found that the same successful sults were obtained in human beings. That same ear the *Journal of the American Medical Association* gave its first account of Behring's discovery and s use in human beings. Dr. Hermann Biggs, who t that time was health officer in the City of New ork, returned from Europe with a moderate mount of antitoxin. A severe epidemic of diphtheria as raging in the New York Infant Asylum. Each hild, sick and well, was given 300 units of antioxin, and the spread of the epidemic stopped immediately. Eight thousand dollars was collected through peals of the *New York Herald* for the production f antitoxin, as the city authorities refused to make ny contribution for this purpose. Sixty horses were urchased, and the production of antitoxin begun. he following year (1895) the city began free adinistration of antitoxin to those who could not ay, and there was a drop in mortality from diphheria that year of over 30 per cent. First antitoxin, ter toxin antitoxin, and then toxoid were used as prophylactic measure. The result is shown in the atistics of the State Health Department of Conecticut. In the five-year period between 1895 and 900 there were 6,212 cases of diphtheria reported nd 1820 deaths. During the same period about 45 ears later, that is, from 1940 to 1945, there were 30 cases reported and no deaths.

I have dwelt on diphtheria somewhat at length because if it had not been practically conquered otolaryngologists would probably still be doing many tracheotomies or intubations and spending a good deal of time giving the meticulous after-care that these procedures entail.

The disappearance of diphtheria as a cause of death is undoubtedly one of the factors that has increased the longevity of man in this country in the last half century. A boy born in 1900 had a life expectancy of 48 years. A boy born in 1940 had a life expectancy of 62 years: that is, in 40 years the expectation of life has been increased by 14 years. Women, for some reason which I will not attempt to explain, live on the average of from 3 to 5 years longer than men. Since the introduction of chemotherapy in respiratory and other infections in the last decade, it is probable the expectation of life by 1950 will be about 65 years. This brings up an interesting social and economic problem: What are we going to do with all the old men and women who are supposed to be beyond working age? What percentage of our people make adequate provision for their old age I do not know, but I imagine it is rather small.

I imagine that very few men who are now 70 years of age realize that they have already lived more than 20 years on borrowed time!

A second contribution that has changed the practice of otolaryngology was the development of the modern laryngoscope, bronchoscope and esophagoscope by that remarkable man, Chevalier Jackson of Philadelphia. The Kilian instruments which antedated his work were rather clumsy—used either with a head light, or an electric lamp attached to the proximal end of the instrument. In 1902 Dr. Jackson was the first to have the light at the distal end which gave a much better view of the tissues to be examined. From then on he has worked constantly to improve these instruments and develop new ones. He was also a great teacher and held classes twice a year to which students came from all over the world, so that now bronchoscopy is a very common procedure and there is probably no hospital of any size in this country where a bronchoscopist is not available.

A third event which has changed the practice of otolaryngology is the general use of the sulfanamides and penicillin in upper respiratory infections in the last decade. With their use the spread of

acute infections of the middle ear to the mastoid so that surgical intervention is necessary, simple mastoidectomy has been cut so much that even in the larger centers they are finding difficulty teaching the house staff the technique because of lack of material. For example, in the Waterbury Hospital during the years 1934 and 1935, 69 simple mastoidectomies were performed. In the years 1944 and 1945 there were only 4—a drop of 94.2 per cent in ten years.

Dr. E. Terry Smith in his letter speaks of Dr. Henry Swain of New Haven as the first person to be elected a member of the American Laryngological Association. This association, founded in 1878, and the American Otological Society were the first national societies, in our specialty. There is at present one member from Connecticut in each of these organizations. In 1895 The American Laryngological, Rhinological and Otological Society, Inc., commonly known as the Triological, was organized. At the present time there are eleven members of this society in active practice in Connecticut.

In 1916 the American Academy of Ophthamology and Otolaryngology appointed a committee of 3 members to examine candidates in otolaryngology. This was later enlarged to ten examiners. The objects of the Board are to establish the qualifications for the practice of otolaryngology and hold examinations to certify those laryngologists whom the board finds qualified. Passing these examinations automaticall allows admission to the Academy. There are a present in Connecticut 55 members of this organi zation.

The Ear, Nose and Throat Section of our Stat Medical Society was founded in 1923. Eugene M Blake of New Haven was the first president; Harr Berman of Hartford, secretary and treasurer, an E. Terry Smith of Hartford, chairman of the Pro gram Committee. There were 32 members presen at this first meeting. There are at present 111 mem bers in this section.

In 1946 there were in active practice in Con necticut 38 otolaryngologists, 33 ophthalmologist and 38 combining ophthamology and otolaryngol ogy.

To the younger members of our profession i general it may be interesting to note that the firs State Board examinations for a license to practic medicine in Connecticut were given in 1895. Befor that anyone who had graduated from medica school was eligible to "hang out his shingle" to prae tice medicine without further examination.

This sort of brings us back to the present time The scope of otolaryngology during the last fift years has been reduced by the disappearance o diphtheria, somewhat broadened through diree examinations of the larynx, trachea and bronchi and of late once more curtailed by the very marke reduction in mastoid surgery by chemotherapy.

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EDITORIALS

Lest We Forget

As members of an important social group facing the problems of a new year, the attention of practicing physicians must continue to be directed to the efforts on the part of certain political leaders to effect legislation which would radically change our present sociomedical relationships. We must not forget that, in addition to those whose activity is purely a matter of politics, there is a considerable number of well-meaning people who, in one way or other, have become convinced that the remedy for many of our social ills is a rather simple matter of the expenditure of vast sums of money administered under central federal control. As physicians we must not only keep informed as to what is going on, but we have a duty to the public as well as ourselves to actively oppose any contemplated legislative action which would affect the health and welfare of the people which is not based on sound economic principles. The dangers inherent in the kind of paternalism which some have proposed to integrate in our social structure are not new, for they have been recognized by thoughtful men for a long time. A century ago DeTocqueville, a profound student of the American "experiment" in democracy, states that, although a powerful centralized "administration can bring together at a given moment, on a given front, all of the disposable resources of a people, it injures the renewal of those resources. It may insure victory in the hour of strife, but it gradually relaxes the sinews of strength. It may help admirably the transient greatness of a man, but not the durable prosperity of a nation." There is indeed something very strange in the eagerness with which some politicians would change a system of government under which we have become the wealthiest and most influential nation in the world; a country to which all nations are now looking for material aid in order to survive. Our system may have its faults, but under it we have not fared so badly. No one would thoughtfully advocate a stand-pat policy in planning our future social structure and we can insist that the approach to the solution of our social problems be paved with common sense. We can insist that our feet remain on the ground even at times when our head is in the clouds. The principles which guided our forefathers to build the system under which we have prospered so well greatly impressed the author previously quoted, for he also wrote: "What is understood by a republican government in the United States is the slow and quiet action of society upon itself. It is a regular state of things really founded upon the enlightened will of the people. It is a conciliatory government, under which resolutions are allowed time to ripen; and in which they are deliberately discussed, and are executed only when mature." Our greatest task is to make sure that these same principles are not forgotten today and that the public is kept sharply aware of the inherent dangers in all social planning which depends basically on centralized government control.

Personality and Practice

The treatment of a disease may be entirely impersonal; the care of a patient must be completely personal.

Francis Peabody

Many of the physicians who happen to be members of the Society of the Sigma Xi have doubtless read an anonymous article which appeared in the autumn issue of the Society's official journal, *American Scientist*, under the caption "Machine Age Medicine." The writer is obviously an intelligent individual with scientific training, an excellent command of the English language, and a clear though somewhat pungent style.

The main thesis of his article, to put it broadly, is that the increasing technical trend in medicine has resulted in the transformation of practice from a profession to a business, and in changing the specialists in various branches of medicine from sympathetic human beings to scientists in whose veins circulates not blood but ice-water. The opening sentence in his article gives a key to its tone: "The practice of medicine has become big business." He comments on the fact that in the cities "the old time family doctor has largely disappeared, and in his place are cold-blooded specialists, aloof and detached." He enumerates their characteristics in detail: lack of interest in symptoms, an assumption that the patient is, *ipso facto*, a dumb egg, remoteness, and, in general, the characteristics usually associated with pompous and opinionated stuffed shirts. But this is not the whole sad story for, according to this critic, the few general practitioners who remain in cities are Caspar Milquetoasts, lacking in both knowledge and self-confidence, who refer their patients to "Aesculapian Oracles" because, overwhelmed by the mass of new discoveries in medicine, they hesitate to treat them themselves. "They have become medical directories," he says, "whose function appears to be to recommend specialists. For this service they usually charge their normal office fee," which, considering that they presumably examine the patient before referring him, seems not unfair. The rest of the communication describes the proceedings of various types of specialists and recounts the transfer of the harassed patient from one variety to another and his final deposition in the lap of some unfortunate neuropsychiatrist, evidently of the Freudian School. All in all it is a piteous tale, calculated to bring tears to the eyes of even a pathologist, and the writer of this editorial would be the last to deny that it could happen. Indeed, one can well imagine that a performance such as this patient describes might easily result in a very natural reaction leading to this kind of indictment.

The trouble with the picture is that it is somewhat out of focus, and that the writer, who perhaps has been put through a medical "third degree," has drawn the conclusion that his experience is the usual one. He apparently does not know that there are plenty of figures to show that the common diseases are simple and easily handled by the general practitioner, and that patients referred to specialists usually present an obscure and perhaps complicated picture, although some, notably neurotics, are referred because they themselves demand it. It is rather curious that these charges should have appeared at the very time when the American Medical Association, the official representative of the Nation's largest body of physicians, is glorifying the General Practitioner and offering *new* ways of keeping him abreast of the advances in medicine. One wonders, too, whether the critic is aware of the numerous staff meetings held by hospitals, of the educational activities of city, county, state, and national medical societies, of the clinical conferences staged by local and national associations, and of the flood of medical literature, much of which is available in one form or another to both general practitioners and specialists. It is true that neither attendance at medical meetings nor reading of medical literature is obligatory, and that much depends on the industry of the individual practitioner, and it is likewise true that no mind can compass the advances in the entire field of medicine. Nowadays the same situation holds in many other callings, though not always to the same degree, and must be overcome by publications which correlate and synthesize knowledge. In medicine there have been such journals for years.

As to the organization of the busy doctor's office, this is more formal, and indeed more businesslike, than it was a couple of generations ago. It is notorious that in the horse and buggy days many doctors were exceedingly lax in the conduct of the business side of their profession. I assume that the critic would agree that in order to practice medicine successfully it is necessary to have the funds to purchase food, shelter and the other accessories necessary to support and raise a family. Then perhaps he has overlooked the fact that there is an agency known

is the Internal Revenue Department which demands accurate figures in connection with the declaration of an income tax and the allowable deductions. So that there are excellent reasons why sensible physicians have become more businesslike than they were forty or fifty years ago. However, it must be admitted that there are some physicians in whose eyes the almighty dollar looms larger than in those of others, in a word there are physicians who charge all that the traffic will bear as if the fact that they treat many patients free were an excuse for this, which it is not. But here again we are not dealing with the decent majority who despise such actions as well as condemning fee splitting, rebates from supply houses and the like.

But, when all this has been said, the fact remains that the most important criticism in the anonymous article is the accusation of a lack of humanity in the specialists of today, who, by the way, constitute about 50 per cent of the regular profession. Science, of course, must be impersonal, but medicine is not a science, being compounded of both science and art. It is hardly necessary to point out that all types of individuals go into medicine and not all from the same motives. We have our misfits, our shysters and our stuffed-shirts, just as do the Law and the Ministry, but they constitute a small minority, and there has never been a time when the mass of the profession failed to grasp the importance of satisfactory personal relations between physician and patient, indeed, as Peabody says, "the essence of practice is that it is an intensely personal matter." Confidence in the physician is at all times important, and it is hardly heresy to say that in some situations it is more important than modern methods of treatment. A patient is expecting too much, however, if he visits a strange consultant and expects of him the same familiarity and camaraderie that he would get from his old family doctor, but he is certainly entitled to a sympathetic hearing and kindly treatment; if he fails to get these he has probably had the bad luck to fall into the hands of a tactless and inconsiderate practitioner, though not necessarily an incompetent one. There is perhaps truth in the idea that some men who are immersed in the study of medical science lack sympathy and facility in handling patients, though this is by no means necessarily the case and is equally true of some general practitioners. As the French put it: "L'Amour de la medécine fait le savant, l'amour du malade fait le medécin," or in Francis Peabody's words: "the secret of the care of the patient is in caring for the patient."

G. B.

Thirteen Out of One Hundred

Eli Lilly Company has published the result of a survey of drug stores in the United States which may be a revelation to the physician as well as a source of disillusionment to the pharmacist. The majority of drug stores were found to be located in cities with populations between 100,000 and 500,000. Only 13 per cent of the nation's drug stores fill more than 40 prescriptions a day.

The chairman of the Professional Pharmacy Committee of the Connecticut Pharmaceutical Association in a recent issue of *Connecticut Pharmacist* points out that there is something wrong with a situation where only 13 out of every 100 drug stores even approach full time professional occupation. We agree with Mr. Kazin. His solution to the problem is a "complete investigation," following the prescription from the time it is written to the point where the patient receives the finished product. To this method of restoring the drug store to its original function of a pharmacy we do not agree. It would afford a full time job for some ardent research enthusiast but, unless each prescription in a given city of over 100,000 souls was followed to the patient for whom it was intended, little would be accomplished.

Pharmacy, like medicine, is advancing rapidly. To keep abreast of new developments postgraduate instruction is a must. This applies to pharmacy just as much as to medicine. Such instruction at regular intervals is an inspiration to the individual who exposes himself to it and, unless he is sadly lacking in ambition, creates a desire for personal improvement in his chosen field which no amount of reading or correspondence school methods can accomplish. The advancement of professional pharmacy like the advancement of professional medicine cannot be secured by expensive surveys nor by the mere social gatherings at conventions but by downright hard work in the form of continued study. The pharmacist like the physician must continue to be a student of the science as well as the art of his profession. When this occurs the snack bar and gadget counter will find themselves in unpleasant company and will move around the corner where they rightfully belong.

Our Student Members

The addition recently of eighty-four student members, new to our Society, brings the present membership to 109. This is a fine showing on the part of those who are responsible for this forward looking plan, and following our lead similar projects also have been established by other state societies. Many of our student members receive the JOURNAL, for which they pay one half of the regular subscription price. This is one of the ways by which they may learn of the Society's activities and the medical happenings back home. However, we should seek to develop this opportunity further and the suggestion has been made that the county societies might develop plans for establishing a closer relationship with medical students from their communities. Such an interest by members of the profession can mean a great deal to the student who for the first time is coming in contact with the traditions of medicine. In this way he will find that these great common interests extend widely outside of the medical classroom. One of our student members writes: "Knowing that one's State Medical Society is interested in its future physicians enough to set up a fine plan such as this gives the younger men a certain added feeling of attachment and interest." Another young man seeking membership says: "One of my classmates informed me of the wonderful opportunity you are giving to interns, in that they are allowed to join the Medical Society, etc. Insomuch as I expect to practice in Connecticut, I am very interested in finding out whether this opportunity can be afforded me."

In working out a program which seeks to interest students of medicine in the scientific and social responsibilities of medical practice, we would do well to remember that it is a mutual interest and that these future doctors deserve more than paper recognition.

A Better Understanding

The physicians of Massachusetts are endeavoring to bring some orderly thinking and good behavior into the confusion surrounding the relationship between employed physicians and hospitals.

A statement of policy has been signed recently by representatives of the Massachusetts Medical Society, the State Hospital Association, Massachusetts Medical Service and Massachusetts Hospital Service. This statement specifically recommends that all bills for medical services rendered in hospitals be collected in the name of the physician rendering the service and urges that, "The medical cost of hospital care be separated from the non medical cost."

This subject has been discussed often in Connecticut and it is difficult to see why this policy which has so much to commend it, has not been adopted here. It is usually said that the chief reason for its non acceptance is the complication of accounting procedures, but these cannot be insurmountable, at least Massachusetts does not think they are, because the four organizations deeply concerned with medical care in the Commonwealth have agreed:

"1. That the medical cost of hospital care be separated from the non medical cost as can be done by existing and accepted methods of cost accounting and that they appear thus separated on the statement submitted to the patient.

"2. That bills for all medical services be rendered in the name of the physician or physicians performing the service."

With the good moral courage that is somehow expected from Massachusetts, the committee emphasizes Section 5, Article VI of Chapter III of the "Principles of Medical Ethics of the American Medical Association." A principle which alas is often overlooked.

"It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people and is against sound public policy."

Then the committee says, "that a basic principle in the establishment of charges should be that each department be self-supporting. This principle should be so applied that neither the hospital nor physician rendering the service will exploit the patient or each other."

Some hospital administrators may look upon this as revolutionary and impractical, but it will be hard to question the basic honesty of it.

Active to Emeritus

(From the Meriden Record, January 5, 1948)

Now and then occurs some climax in community vents which brings home to us the "speed of time infinite." Dr. Murdock's resignation from his leriden Hospital duties is such an occasion. It omes as a shock when a prominent man who has lentified himself with public affairs connected with is profession to the extent of Dr. Murdock's par- cipation in Meriden's welfare says the "time has ome" for him to call a halt. It is almost incongruous o think of him in the emeritus class. Great energy, ommanding personality and unlimited understand- ig are combined in his person to create an impres- on of everlasting endurance.

But time and duties take their toll. Dr. Murdock eels he has neglected too long the care of his own ealth. Duties that take him far afield from Meriden connection with activities of state and national edical organizations are as much as he should oulder in addition to his normal practice. So he ks release from the responsibilities at the Meriden lospital where his guiding hand has been at the elm for a quarter of a century.

Society has a way of overtaxing a willing servant. esponsibility for standards of efficiency at an stitution as important as the Meriden Hospital is heavy load. Dr. Murdock and his fellow doctors ho have acted as heads of departments and services erform their duties at the expense of great personal crifice. There is honor in the position, and plenty f satisfaction in knowledge of work well done. ut the cost in time and energy is tremendous. The ad is so great that it should be more widely dis- ibuted in fairness to everyone concerned.

Dr. Murdock retires from one phase of his career a shower of expressions of gratitude and appre- iation from those who have benefitted directly or directly by his skillful leadership. May the lessen- g of his burden bring him the relief he craves, estore his health, and allow him full scope for the aried interests which always have and always will laim him and his talents.

Eye Bank for Sight Restoration

At the end of two years the accomplishments of he Eye Bank for Sight Restoration, Inc., command he attention of both layman and physician. Con- ibutions through membership support have in- creased about 50 per cent and the total receipts for the year ending April 30, 1947 were over $100,000. During the second year of its existence affiliate eye banks were established in Boston and in New Orleans. In these two years over 600 eyes have been given by the public and accepted by the laboratory as being suitable for use. 80 per cent of the cases carefully selected for operation have resulted in definite and often dramatic improvement in vision. Scholarships have been granted to physicians to receive training in the technique of the corneal graft operation and to observe research work going on in the Eye Bank laboratory. Surgeons have come from India, China, France, England, and the Philippines at their own expense for training at the Eye Bank. The achievements of these first two years of the Eye Bank serve as one more example of the remark- able progress of American medicine.

Connecticut Manufacturers Arrange New Hospital Insurance

The Manufacturers Association of Connecticut has approved a unique type of hospitalization plan submitted by the Aetna Life Insurance Company. This plan will furnish insurance coverage ranging from $6 to $10 per day *in addition* to any other hospital insurance now in force on supervisory, administrative, professional or sales personnel. The cost of this plan is said to be extremely modest. The need for it has come about because of the 75 to 100 per cent increase in hospital rates during the past few years. The Association has appointed a Group Hospitalization Committee to supervise the opera- tion of the new plan.

Interest Growing in AMA Chicago Meeting

Plans are already developing for the annual American Medical Association session in Chicago June 21-25, 1948, with several national medical organizations scheduling meetings during the pre- ceding week.

Dr. Morris Fishbein, editor of the *AMA Journal*, reports there are indications already that Chicago hotel facilities will be taxed to capacity for the '48 session. He said that a two-page rate schedule of Chicago hotels will appear in *The Journal* shortly after the first of the year and suggests that physi- cians planning to attend make their reservations as early as possible.

THE PRESIDENT'S PAGE

According to a recent article in a popular magazine, the practice of giving and receiving rebates, commissions, and so-called "kick-backs" is flourishing in certain cities. Physicians are under indictment for receiving rebates from pharmacists, opticians, and makers of orthopedic appliances, all unknown to the patient.

Whatever may be the practice in the world of business, the profession demands of its members that the giving or receiving of rebates be abjured. Splitting of fees is recognized in the oath of the American College of Surgeons as contrary to ethics and detrimental to the welfare of the patient.

Over and over again this practice has been denounced by organized medicine, never so clearly, however, as in a recent statement by the officers and Board of Trustees of the American Medical Association. This statement points out that the mechanisms for correction are clearly outlined, and are the powers of the County Medical Associations.

J. R. Miller

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

JAMES G. BURCH
Public Relations

258 CHURCH STREET, NEW HAVEN
Telephones: 5-0249, 5-0836

Council Meeting

The regular monthly meeting of the Council was called to order by the Chairman at 3:30 P. M. on Friday, December 19. There were present: Dr. Murdock, the Chairman, Drs. Gildersleeve, Weld, Burlingame, Thoms, Weed, Phillips, Miller, Speight, Parmelee, Howard, Harvey, Barker and Miss Mooney. Absent: Drs. Gibson and LaMoure. In addition to members of the Council, there were also present Dr. Courtney C. Bishop, New Haven, chairman of the Committee to Study the Organization and Objectives of the Society, and Dr. William Mac Shepard, Putnam, a member of the committee.

BUDGET SUPPLEMENTS

Additional allotments to offset budget deficits for 1947 for the Committee on Public Relations and the JOURNAL were voted.

STANDARDS FOR CANCER DETECTION CENTERS

The report of the special committee appointed for the purpose of setting up minimum standards for cancer detection centers was discussed at length and adopted. The members of the committee were Bliss B. Clark, M.D., New Britain, chairman; John B. Ogilvie, M.D., Stamford; Max Taffel, M.D., New Haven, and the report follows:

MINIMUM STANDARDS FOR CANCER DETECTION CENTERS

The Council of the State Medical Society is authorized to approve such cancer detection centers as are recommended to it by the Council's Special Committee on Cancer Detection Centers as having fulfilled the minimum standards.

THE POLICY OF THE CONNECTICUT STATE MEDICAL SOCIETY

The Connecticut State Medical Society recognizes the importance of periodic physical examinations, especially in persons over forty years of age for the purpose of early detection of chronic diseases with special emphasis on the early detection of cancer.

Therefore, the Connecticut State Medical Society strongly urges its members to adopt a regular program of complete periodic health examinations of all patients after middle life seen in private practice. The Connecticut State Medical Society also strongly urges the public to seek regular periodic complete physical examinations by their family physicians.

Further, the Connecticut State Medical Society endorses the establishment of cancer detection centers, provided such centers meet the minimum standards adopted by the Connecticut State Medical Society and have the approval of the County Medical Association in the county in which the center is located.

The Connecticut State Medical Society's Minimum Standards for Cancer Detection Centers.

Purpose: The purpose of the cancer detection center shall be to make periodic physical examinations of presumably well persons to discover early chronic diseases with special emphasis on the early recognition of cancer or lesions that may lead to cancer.

Definition: (of the American Cancer Society and approved by the AMA).

"Cancer detection, cancer prevention or well-person clinic is designed to detect abnormalities not producing symptoms sufficient to send the patient to the doctor."

Eligibility: Patients may be referred to the Detection Clinic by physicians, social and welfare agencies, or they may enter voluntarily.

Discussion: The cancer detection center has proved to be a useful means of discovering early cancer or lesions that may lead to cancer. The center may be a valuable public health measure, but in order to protect the patient both physically and mentally, it is essential that the examinations in this

clinic be conducted with judgment and accuracy. The cancer detection center properly conducted can be the means of saving lives, but if not properly conducted can be a source of great danger. If the examinations in the center are not thoroughly and efficiently made, early cancer may be overlooked and the patient dismissed with a false sense of security which would delay adequate care. Also, failure of the clinics to evaluate suspicious lesions may develop an unfortunate and unjustified cancer phobia.

In order to assure the people of the best type of periodic examinations and to protect the people from incomplete means and unfounded fears, the Connecticut State Medical Society has adopted the following minimum standards for cancer detection centers in Connecticut.

1. The cancer detection center shall have the continued approval and support of the County Medical Association in the county in which it is located. The physicians must be members of that association and the center must have a medical advisory board composed of members of the County Medical Association.

2. The detection center shall be conducted in a hospital approved by the American College of Surgeons or in the outpatient department of an approved medical school or under conditions permitting compliance with the other features of this standard.

3. The center shall be supervised by a physician or physicians who have training and experience in the diagnosis and treatment of cancer.

4. The center shall have proper housing and adequate facilities and supplies to conduct the physical examinations. Clinical and radiological laboratories must be easily accessible.

5. A sufficient number of physicians shall be available to conduct the center at regular intervals to provide for complete physical examination for every patient accepted by the center. In addition, consultation with qualified specialists should be available when necessary.

6. Adequate records shall be kept. These shall include the history, physical findings, laboratory and x-ray data, recommendations, and disposition of each patient. Sufficient personnel shall be available to provide the necessary nursing, stenographic and record services.

7. The examination shall include: (a) history; (b) complete physical examination, including digital rectal examination and, in adult females, a pelvic examination performed preferably by a gynecologist; (c) routine blood count, urinalysis, stool for blood, and blood serology; (d) x-ray film of chest; (e) Papanicolaou vaginal smear in adult female patients.

8. Patients that present suspicious history or abnormal physical findings shall be referred to their family physicians for further diagnosis and treatment. If there is no family physician, the patient shall be referred to a physician or clinic as directed by the policy established by the County Medical Association.

9. A summary of the pertinent facts and recommendations of the center shall be sent to the physician or clinic to whom the patient is referred.

10. One month after such referral to physician the case shall be followed up by letter or social service visit and complete report of diagnosis and treatment shall be obtained.

11. Only presumably well patients will be accepted for examination. No patient under treatment for cancer will be accepted without permission of the patient's attending physician.

12. A contribution of a specified sum of money toward expenses of the center shall be required of examinees who are able to pay. This shall be collected in the name of the institution conducting the center.

13. All publicity and promotional material issued by the center shall have the approval of the Medical Advisory Board of the center and no extravagant misleading or sensational methods shall be permitted.

RECOMMENDATIONS OF THE COMMITTEE ON PUBLIC HEALTH

Four recommendations received by the Council from the Committee on Public Health were acted upon as follows:

A. It was voted to table a recommendation concerning fees paid to physicians by the State Department of Health or any of its agencies pending the outcome of a study of fees paid by state agencies now being made by a special committee appointed by the State Department of Finance and Control.

B. A recommendation concerning instruction for teachers of the deaf was approved and the secretary was directed to inform the Commissioner of Education of the State of Connecticut that the Society urges that courses for the instructing of teachers of the deaf be included in the curricula of state teachers' colleges.

c. The secretary was instructed to communicate ith the State Commissioner of Health urging the ganization of additional hearing clinics modelled ter the one now operating in Hartford.

D. A recommendation concerning the enactment laws to require compulsory education of the deaf rough the eighth grade was approved.

ONFERENCE OF PRESIDENTS AND SECRETARIES

It was voted to hold a Conference of Presidents d Secretaries in the spring of 1948.

TUDENT MEMBERS

Eighty-four student members were elected and e list follows these minutes.

. S. SAVINGS BONDS

A request from the Treasury Department for permission to solicit the sale of savings bonds among e members of the Society was approved.

1948 SOCIAL HYGIENE DAY

The Council voted to participate as usual in Social Hygiene Day on February 4, 1948 and designated Dr. Joseph I. Linde as the Society's representative.

COMMITTEE NOMINATIONS FOR 1948-1949

It was voted that the Chairman of the Council appoint a nominating committee of three members of the Council including himself and that this committee prepare a preliminary list of proposals for nominations to committees for the year 1948-1949 to be presented to the Council for consideration when final action is taken on nominations.

TWENTY-FIFTH ANNIVERSARY OF DR. OSBORN

It was voted that the congratulations of the Council and the Society be extended to Dr. Stanley H. Osborn on the occasion of his twenty-fifth anniversary with the State Department of Health.

STUDENT MEMBERS

braham E. Alpert
ew Haven, Conn.
lass–1949–Creighton Univ.

homas T. Amatruda, Jr.
ew Haven, Conn.
lass–1951–Yale Med. School

obert E. Appleby
orwalk, Conn.
lass–1949–Johns Hopkins Univ.

obert W. Bell
anielson, Conn.
lass–1948–Boston Univ.

oseph W. Belkin
ew Britain, Conn.
lass–1949–Maryland Univ.

ichard E. Bouchard
ridgeport, Conn.
lass–1949–Univ. of Vermont

William R. Bradley
New Haven, Conn.
Class–1949–New York Med. College

dward S. Bundy
outhington, Conn.
lass–1948–Univ. of Vermont

dith L. Carrier
artford, Conn.
lass–1949–Cornell Med. College

rank K. Corbett, Jr.
helton, Conn.
lass–1950–New York Med. College

lbert J. Costello
ncasville, Conn.
lass–1949–Creighton Univ.

William J. A. DeMaria
Westport, Conn.
Class–1947–Duke Univ.

Albert H. Dolinsky
Winsted, Conn.
Class–1950–New York Medical College

James Dougherty
Hartford, Conn.
Class–1951–Albany Med. College

Lyon H. Earle, Jr.
West Hartford, Conn.
Class–1950–Tufts College

Harry E. Eaton
Willimantic, Conn.
Class–1949–Univ. of Vermont

Gunnar O. Eng
Stamford, Conn.
Class–1949–Yale Med. School

William H. Faeth
Waterbury, Conn.
Class–1949–Tufts College

Mary A. Falorsi
Waterbury, Conn.
Class–1950–Johns Hopkins Univ.

Edward A. Felder
Norwich, Conn.
Class–1948–Jefferson Med. College

Arnold Feldman
Bridgeport, Conn.
Class–1949–Univ. of Pittsburgh

James C. Ferrucci
Bridgeport, Conn.
Class–1948–Tufts College

Allen A. Fierberg
Hartford, Conn.
Class–1949–Univ. of Pittsburgh

Lawrence R. Freedman
New Haven, Conn.
Class–1950–Yale Med. School

Leo P. Giardi
Hartford, Conn.
Class–1948–Univ. of Vermont

Eli Gold
Hamden, Conn.
Class–1950–Western Reserve Univ.

Archie J. Golden
New Haven, Conn.
Class–1950–Yale Med. School

Ira S. Goldenberg
Bridgeport, Conn.
Class–1951–Boston Univ.

Sumner Goldenthal
New Haven, Conn.
Class–1950–Yale Med. School

William V. Golkowski, Jr.
West Haven, Conn.
Class–1948–Albany Med. College

Norman D. Gross
West Hartford, Conn.
Class–1949–Creighton Univ.

Walter E. Gustafson
Manchester, Conn.
Class–1949–Yale Med. School

Robert N. Hamburger
Hamden, Conn.
Class–1951–Yale Med. School

William F. Hart, Jr.
West Hartford, Conn.
Class—1949—Jefferson Med. College

Monroe Himelstein
Hartford, Conn.
Class—1951—Columbia Univ.

Nelson D. Holmquist
Bristol, Conn.
Class—1951—Columbia Univ.

Michael Hume
New Milford, Conn.
Class—1950—Columbia Univ.

Sidney Hurwitz
West Haven, Conn.
Class—1949—Long Island College

Robert F. Jones
Cromwell, Conn.
Class—1950—Columbia Univ.

Paul J. Kingston
East Hartford, Conn.
Class—1950—New York Med. College

George W. LaFlash
Hartford, Conn.
Class—1951—Columbia Univ.

Charles H. Lanzieri
Waterbury, Conn.
Class—1951—New York Med. College

Lucian S. Lapinski
Bridgeport, Conn.
Class—1950—Yale Med. School

Stanley R. Lavietes
New Haven. Conn.
Class—1949—Baylor Univ.

Sidney S. Lee
New Haven, Conn.
Class—1950—Yale Med. School

John B. LeRoy
Hartford, Conn.
Class—1950—Yale Med. School

Maurice N. Levy, Jr.
Bridgeport, Conn.
Class—1949—Harvard Med. School

Robert W. Lusk
New Haven, Conn.
Class—1951—Yale Med. School

Margaret S. Lyman
Middlefield, Conn.
Class—1950—Yale Med. School

Lawrence L. Malinconico
West Haven, Conn.
Class—1951—Tufts College

Paul R. McCurdy
Middletown, Conn.
Class—1949—Harvard Med. School

James E. Mitchell
Lyme, Conn.
Class—1949—Johns Hopkins Univ.

Charles F. Montague, Jr.
Darien, Conn.
Class—1951—Pennsylvania Univ.

Timothy F. Nolan, Jr.
Middlebury, Conn.
Class—1949—Yale Med. School

William V. Palluotto
New Haven, Conn.
Class—1950—New York Med. College

Victor A. Palumbo
Middletown, Conn.
Class—1950—Tufts College

David W. Parke
Meriden, Conn.
Class—1950—Ohio State Univ.

Richard C. Peterson
Wethersfield, Conn.
Class—1948—Yale Med. School

Carlton C. Phillips
New Haven, Conn.
Class—1949—Louisville Univ.

Majic S. Potsaid
East Haven, Conn.
Class—1951—Yale Med. School

Warren J. Reinhard
Bridgeport, Conn.
Class—1951—Jefferson Med. College

Clayton Rich, Jr.
North Stamford, Conn.
Class—1948—Cornell Med. College

Charles A. Robbins, Jr.
Andover, Conn.
Class—1951—New York Med. College

Sidney Rosen
New Haven, Conn.
Class—1951—Yale Med. School

Seymour H. Saltzman
Hartford. Conn.
Class—1951—Syracuse Univ.

Robert T. Sceery
West Harftord, Conn.
Class—1950—Yale Med. School

Michael M. Scialla
Bridgeport, Conn.
Class—1948—Western Reserve Univ.

Jay B. Skelton
Riverside, Conn.
Class—1951—Cornell Med. College

Alan R. Small
Bridgeport, Conn.
Class—1948—New York Med. College

David H. Spodick
Hartford, Conn.
Class—1950—New York Med. College

Robert H. Sturman
New Haven, Conn.
Class—1950—Yale Med. School

Raymond D. Sudarsky
Hartford, Conn.
Class—1949—Yale Med. School

John L. Sullivan
Bridgeport, Conn.
Class—1951—Yale Med. School

Robert D. Terry
West Hartford, Conn.
Class—1950—Albany Med. College

Elsie M. Tytla
New London, Conn.
Class—1951—Woman's Med. College o
Pa.

Joseph F. Uricchio
Hartford, Conn.
Class—1949—Tufts College

Eugene M. Vigneron, Jr.
Salisbury, Conn.
Class—1949—Harvard Med. School

Sherman L. Waldron
Wapping, Conn.
Class—1950—Tufts College

William L. West
Shelton, Conn.
Class—1948—Univ. of Vermont

Howard J. Wetstone
Hartford, Conn.
Class—1951—Tufts College

Fowler F. White
Hartford, Conn.
Class—1950—Maryland Univ.

Clifford E. Wilson, Jr.
Norwichtown, Conn.
Class—1950—Maryland Univ.

Michael A. Yedziniak
Hartford, Conn.
Class—1951—Geo. Washington Univ.

Louis R. Ziegra, Jr.
Deep River, Conn.
Class—1951—New York Med. College

Meetings Held During January

riday, January 9, 4:00 P. M.
Program Committee, 789 Howard Avenue
Vednesday, January 14, 4:00 P. M.
Committee on Maternal Morbidity and Mortality
Vednesday, January 28, 3:30 P. M.
Special meeting of the House of Delegates, Hunt Memorial, Hartford
Council of the Society, Hartord Club
hursday, January 29, 3:30 P. M.
Committee on Public Health

Meetings Scheduled for February

hursday, February 5, 2:00 P. M.
Advisory Committee to the State Board of Examiners for Nursing, Hartford

Secure Funds for World Medical Association

The U. S. committee of the World Medical ssociation, designed to foster closer relationships mong the national medical associations of the orld, has been actively engaged in securing funds o support the project for at least five years.

Judging from the fine response already received rom industrial contributors, there is a great amount f interest in the project. The committee is now onsidering the formation of affiliate memberships o members of the medical profession, who would ontribute $10 a year. Dr. E. L. Henderson, Louisille, Ky., is chairman of the U. S. committee.

The money will be used for the provision of a ermanent office, the remuneration of a full time ecretary and staff and the running costs of the ecretariat, with the U. S. committee, made up of hysicians and laymen, administering the funds.

Red Cross-Philadelphia County Society Blood Bank

An agreement has been reached between the Southeastern Pennsylvania chapter of the American Red Cross and the Philadelphia County Medical Society for the establishment of a central blood donor service. The program entails securing whole blood on a voluntary basis which will be made available without charge to anyone needing a transfusion who is not in a position to pay for the necessary blood. It is intended that this service shall supplement, but not supplant, the present operation of blood banks in hospitals.

A definite understanding has been reached between the Red Cross and the Medical Society with regard to the many technical and professional considerations involved in the plan, among which is the provision that the blood collected will be completely processed by the Red Cross, including typing, serology tests and the determination of the Rh factor, and that these procedures shall be supervised by qualified doctors of medicine.

New England Postgraduate Assembly

Final reports from the sixth annual New England Postgraduate Assembly showed that all previous attendance records had been broken. Over 700 physicians attended from New England, California, Illinois, New York, New Jersey, and Canada. The committee in charge of the Assembly, comprising representatives from the six New England state societies, was confronted with a decision whether to change its parenthood, so to speak, from the Massachusetts Medical Society as at present to a new organization created for this one function. A vote against any change was recorded, and therefore the Massachusetts Society will continue to foster this young child, to be the financial guarantor as well as the host to each annual session.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, DECEMBER 10 TO JANUARY 10

Fairfield County
Morrissett, L. E., Greenwich

Hartford County
Brennan, E. L., Hartford
Klein, Joseph, Hartford
Zarkin, Oscar, Hartford

New Haven County
Rand, R. F., New Haven

Dr. Hastings Appointed to Medical Examining Board



CHARLES J. BARTLETT, M.D.

Dr. Louis P. Hastings, of West Hartford, was recently appointed to the Connecticut Medical Examining Board by Governor James L. McConaughy to fill a vacancy created by the resignation of Dr. Charles J. Bartlett of New Haven.

President of the Hartford County Medical Association, Dr. Hastings received his medical degree from the University of Vermont in 1923. He completed his internship at the Mary Fletcher Hospital, Burlington, Vermont, and later became assistant professor of clinical pathology and bacteriology at the University of Vermont College of Medicine. He has been a pathologist on the full-time staff of the St. Francis Hospital, Hartford, since 1929.

Dr. Bartlett was president of the Board at the time of his resignation, and his membership was continuous for more than 20 years. He is a former president of the New Haven County Medical Association, and in 1918 served as president of the State Medical Society.

His pre-medical education was completed at Ya University, and following graduation from the Ya University School of Medicine in 1895, he we abroad for further study at Leipzig, Germany. H returned to Yale University to teach pathology, an in 1897 was named assistant professor in that depar ment. In 1900 he received appointment as Profess of Pathology, a post in which he continued unt he became Professor Emeritus in 1917. From 19 to 1917 he was pathologist and attending physicia on the staff of the New Haven Hospital.

Dr. Bartlett is at present pathologist at the Grac New Haven Community Hospital, a position whic he has held since 1918, and is consultant pathologi for the Charlotte Hungerford Hospital, Torringto and the Griffin Hospital, Derby. His interest public health has been evidenced by long perio of service. For more than 25 years he was a memb of the New Haven Board of Health, and for years a medical examiner for the City of Ne Haven. During World War II he served as a men ber of the State Council for National Defense.



LOUIS P. HASTINGS, M.D.

Dr. Powers Honored by Pediatricians

Grover F. Powers, chairman of the Department f Pediatrics of the Yale School of Medicine, recent- was honored by the American Academy of Pedi- trics with the Borden Award, granted for "out- anding research in the nutrition of infants and hildren."

The Borden Awards were established in 1936 to ecognize and encourage outstanding research chievements in the food industry and related fields. hey are administered by seven professional and cientific associations. Professor Powers received a old medal and a monetary award from the cademy.

Dr. Powers, in his address accepting the award, leclared that a diet containing cow's milk and other dded substances is more satisfactory for feeble, nalnourished, convalescent and premature infants han human milk. This finding is based on twenty ears' experience at the New Haven Hospital, now he Grace-New Haven Community Hospital, of which Dr. Powers is the pediatrician-in-chief.

In June 1947 Dr. Powers was elected president of he American Pediatrics Society. He had formerly been president of the New England Pediatrics Society.

A native of Indiana, he received his B.S. degree from Purdue University in 1908, an honorary Doc- tor of Science degree from the same institution in 1935 and his M.D. from the Johns Hopkins Univer- sity in 1913. From 1913 to 1921 he was on the staff of Johns Hopkins and he has been at Yale ever since with the exception of a year as pediatrician-in-chief of the Henry Ford Hospital in Detroit, Michigan. He is a trustee of the Southbury (Connecticut) Training School and a member of the editorial board of the *Journal of Pediatrics.*

Clinics on Fractures and Other Trauma

The Connecticut Regional Committee on Frac- tures and Other Trauma of the American College of Surgeons has been reorganized and recommitted to a program of encouraging improved treatment of fractures and all other trauma. Seventy key sur- geons of the State have indicated their willingness to cooperate in such a teaching plan. The first clinic day was held in Boston November 14, 1947. Con- necticut was represented on the program by Robert M. Yergason of Hartford who discussed "Hyper- extension Fracture of the Elbow."

In January the New Haven Group of the Com- mittee presented a one day program of papers and discussions at the New Haven Hospital. Future plans call for similar clinic days to be put on by representative groups from their own experiences, including papers, case reports and discussions by members. All physicians interested are invited to attend these meetings and take from them whatever they consider of value. Teaching teams will be developed in this way to further improve treatment and management of trauma. Lay organizations in- terested will be welcome to attend. By raising the standard of capacity of physicians who attend the injured a true free choice of physicians will be made possible. Worthy papers will have arrangements made for suitable publication.

Connecticut to Form Physicians Art Association

A group of physicians interested in art are form- ing the Connecticut State Physicians Art Associa- tion. Any and all physicians interested will be welcomed into the membership. An exhibit will be given by the Association at the State Society Meet- ing in Fairfield in April. Exhibitors in oil, water colors, tempera, etchings, drawing, ceramics, sculp- ture, photography, metal work, woodwork, and needle craft will be invited to participate.

School of Medicine to Expand Postgraduate Program

As a result of conferences between the Com- mittee on Cooperation with the Yale School of Medicine and representatives of the School a post- graduate education plan has been developed which will be a joint enterprise between the State Society and the School of Medicine. Aided by a grant from the Society, the School will appoint a full time director for the project. Not only will courses be developed which will be directed toward the needs of practicing physicians, but the present resident training program in hospitals will be studied with a view to aiding in the expansion of such programs when requested. In order to find out what courses of study may be usefully developed, a questionnaire will be circulated shortly to the members of the Connecticut State Medical Society. A thoughtful consideration and an early return of this communi- cation will be greatly helpful in developing the opportunities of this enterprise.

Presentation of Gift to State Tuberculosis Commission

Climaxing the efforts of more than sixty volunteer associations and committees throughout Connecticut to aid in promotion of the State's mass x-ray survey, Governor James L. McConaughy at the annual meeting of the Connecticut Tuberculosis Association accepted on behalf of the State Tuberculosis Commission a check for $15,000 presented to him by Miss Marion H. Douglas, president of the Association. The gift was made at a meeting of the Commission held at Cedarcrest Sanatorium where Dr. Joseph I. Linde, New Haven, chairman, and Dr. Paul S. Phelps, director of the Department of Tuberculosis Control, participated in the ceremony.

Demonstrating the cooperation of the voluntary tuberculosis associations with the official agencies, Miss Douglas pointed out that over two-thirds of the local associations which are financed through the annual sale of Christmas Seals have voluntarily banded together to make it possible for the Commission to purchase an additional truck or bus to transport its new 70mm x-ray unit for surveys in industrial plants and in local community groups. Provision of such equipment will be of benefit to every community and will speed up the case-finding programs throughout the state.

Improvements in Advanced Training for Army Medical Officers

Improvements in the Army Medical Department graduate professional education program for 1948 aim to place Army teaching hospitals on an equal plane with the best civilian teaching hospitals. Graduate training in psychiatry is being strengthened and concentrated at Letterman, Fitzsimmons and Walter Reed Hospitals. Many qualified consultants will be added to the attending staffs of the teaching hospitals. Administrative responsibilities of qualified teachers will be lessened. More adequate means of resident-intern selection and evaluation of progress are being placed in operation. The present obstacles in the organization of interns and residents into the pryramidal system are being overcome. In December 1947, 204 Regular Army Medical Corps officers were participating in the postgraduate instruction program as residents in the various recognized special fields of medicine and surgery. 50 more positions were made available January 1, 1948 to applicants for the Regular Army who are now in the continental United States and 50 more will be offered to applicants who are overseas, effectiv July 1, 1948.

National Study of Congenital Malformations and Maternal Infection

In an effort to collect more precise data on th relationships between certain maternal infection and congenital malformations, a nationwide stud is being sponsored by the American Academy o Pediatrics and the National Society for the Preven tion of Blindness. Questionnaires are being sent t obstetricians, ophthalmologists and pediatricians seeking the reporting of cases of German measles i expectant mothers and of children with congenita defects that night be attributed to other infection in the expectant mother, such as measles, chicke pox, mumps and influenza.

Although an association has been established be tween the occurrence of German measles early i pregnancy and certain congenital defects in the off spring, information is lacking as to the frequency with which this happens and as to the possible in fluence of other communicable diseaess that migh have been contracted by the expectant mother.

Data will be studied by the following committee: Herbert C. Miller, M.D., professor of pediatrics, University of Kansas Hospitals, Kansas City, Kansas; Stewart Clifford, M.D., and Clement A. Smith, M.D., both of Boston, Mass.; Josef Warkany, M.D., of Cincinnati, Ohio; James Wilson, M.D., of Ann Arbor, Mich.; and Herman Yannet, M.D., of Southbury, Conn. Physicians knowing of cases are urged to register them with Dr. Miller, chairman of the committee.

Post Surgeon

The American Legion is an organization of great influence in local and national affairs, and it furnishes a medium through which physicians can express their ideas, thus helping to shape public policy. Each Post is supposed to have a Post Surgeon, and such an individual can have a strong influence in directing the thinking and actions of the local organization. We would urge that all physicians who are eligible join their local Posts and see to it that an active and clear thinking physician is elected to the position of Post Surgeon.

Announcing

Connecticut's First Cancer Conference for Physicians

THURSDAY, MARCH 25

HOTEL TAFT, NEW HAVEN

Morning, afternoon, and evening sessions

Well-known national figures will discuss cancer, with special emphasis on early detection by family physicians, and means available for early treatment.

The conference is being arranged by the Connecticut Cancer Society, with the cooperation of the Connecticut State Medical Society.

Members of the planning committee:

Donald A. Bristoll, M.D., New Britain, *Chairman*

Samuel C. Harvey, M.D., New Haven
Richard I. Barstow, M.D., Norfolk
Harold A. Bergendahl, M.D., Norwich
Alfred L. Burgdorf, M.D., Hartford
Richard F. Grant, M.D., Cromwell
Homer W. Grimm, M.D., Bridgeport
John C. Leonard, M.D., Hartford

CONNECTICUT CANCER SOCIETY

Tumor Clinics in Connecticut

Patients unable to pay may receive diagnostic services and treatment free of charge by applying to these tumor clinics either through their private physicians, social agencies or public health nurses.

Bridgeport Hospital — Bridgeport
2nd and 4th Friday each month, 11:00 A. M.

Bristol Hospital — Bristol
Last Saturday each month, 11:00 A. M.

Danbury Hospital — Danbury
1st Friday of the month, 10:30 A. M.

Hartford Hospital — Hartford
2nd and 3rd Friday, 10:30 A. M.

McCook Hospital — Hartford
3rd Saturday each month, 11:00 A. M.

St. Francis Hospital — Hartford
Each Wednesday, 11:00 A. M.

Manchester Hospital — Manchester
2nd and 4th Monday each month, 10:00 A. M.

Meriden Hospital — Meriden
2nd and 4th Saturday each month, 10:00 A. M.

Middlesex Hospital — Middletown
1st Wednesday each month, 9:30 A. M.

New Britain General Hospital — New Britain
1st and 3rd Friday. 10:00 A. M.

Grace Hospital — New Haven
Each Tuesday, 11:00 A. M.

St. Raphael's Hospital — New Haven
Each Tuesday, 10:00 A. M.

New Haven Hospital — New Haven
Monday, Wednesday, and Friday, 9:00 A. M.
Gynecological Clinic
2nd and 4th Friday each month, 1:30 P. M.
by Appointment

Lawrence & Memorial Asso. Hospitals — New London
1st and 3rd Friday each month, 9:30 A. M.

Norwalk General Hospital — Norwalk
Each Tuesday, 11:00 A. M.

William W. Backus Hospital — Norwich
Every Wednesday each month, 10:30 A. M.

Day Kimball Hospital — Putnam
4th Monday each month, 10:30 A. M.

Stamford Hospital — Stamford
Each Tuesday, 10:00 A. M.

Charlotte Hungerford Hospital — Torrington
3rd Saturday each month, 10 A. M.

St. Mary's Hospital — Waterbury
Each Wednesday, 11:00 A. M. except Wednesday following first Monday

Waterbury Hospital — Waterbury
Each Friday except 4th, at 11:00 A. M.

Windham Community Memorial Hospital — Willimantic
First Monday each month, 10:30 A. M.

Detection Centers

Bridgeport	114 State Street Ask for Mrs. Smith	Telephone 67-137
Hartford	McCook Memorial Hospital Ask for Mrs. Russell	Telephone 2-486
Meriden	Meriden Hospital Ask for Mrs. Skeba	Telephone: 710
New Haven	New Haven Hospital Ask for Mrs. Maddern	Telephone 6-242

Information Centers

Bridgeport	Cilco Bldg., 114 State Street	Telephone 67-137
Bristol	72 North Main Street	Telephone: 845
Danbury	Danbury Hospital	Telephone: 390
Greenwich	45 East Putnam Avenue	Telephone: 8-020
Hartford	635 Main Street, Room 243	Telephone: 2-486
Manchester	953 Main Street	Telephone: 413
Meriden	Meriden Hospital	Telephone: 710
New Britain	272 Main Street	Telephone: 60
New Haven	1044 Chapel Street	Telephone: 6-242
New Milford	Allen Building	Telephone: 139
Norwalk	Norwalk Hospital	Telephone: 6-255
Torrington	31 Clark Street	Telephone: 2:096
Waterbury	95 North Main Street	Telephone: 3-870

New Ruling on Legacies

Under a new ruling on funds willed in behalf of cancer control, the State Executive Committee voted that such contributions will remain in full with the unit of the Society specified by the benefactor. In that way, the benefactor may name a local branch, the state society or the American Cancer Society as beneficiary.

Polish Language Pamphlet Now Available

The American Cancer Society's new pamphlets written in Polish are now available. They are the same in size and makeup as the Italian language literature recently distributed.

American Cancer Society Fellowships and Grants in Cancer Research

The American Cancer Society, through the Committee on Growth of the National Research Council, is sponsoring a research program encompassing

hose scientific disciplines which may be brought o bear upon the study of growth, typical or malig- ant, including various branches of biological, hemical and physical science and of clinical investi- ative medicine. For those who contemplate apply- ng for a Grant in Cancer Research the following reliminary information is provided.

Application blanks may be obtained from the Committee on Growth, National Research Council, 101 Constitution Avenue, Washington 25, D. C., nd should be returned to that office.

Grants are made for the fiscal year July 1-June o, but are renewable. Applications for new grants o be effective July 1 will be received until the revious November 1. Applications for extension of xisting grants expiring June 30 will be received ntil the previous October 1.

While grants currently are being made for a eriod of one year, both the Committee on Growth nd the American Cancer Society are fully cogni- ant of the importance of continuity in research, and very reasonable assurance is offered that it will be rovided, assuming of course continued public re- ponse to the Society's annual appeal for funds.

Funds are granted to an institution for support of specific research program under the direction of responsible investigator. It is the policy of the Committee on Growth not to recommend payment f any part of the salary of the responsible investi- ator. The grant is made with the further under- anding that the appropriation by the institution to he department concerned will not be diminished.

It is the present policy of the Committee on Growth not to recommend support of hospital beds, ursing care or related services, except in very ex- eptional circumstances.

Institutions receiving research grants are offered n allowance to cover institutional overhead in con- ection with the administration of the grants in an mount not to exceed five per cent of the total of he grant exclusive of the overhead allowance. nstitutions that wish to avail themselves of this llowance should include the appropriate amount s a separate item in paragraph 5 of the application orm.

Funds granted to an institution in support of a esearch project may be used by the institution to neet its contribution, with respect to personnel mployed directly on the project, to its retirement r annuity plan or program for such personnel; provided that such charges to the American Cancer Society grant are consistent with the institution's established practice; and provided further, that the charges to the project are not greater in proportion to the institution's total contribution on behalf of an employee during any period than the employee's salary charged to the American Cancer Society project bears to his total institutional compensation for the same period. The appropriate amounts for this purpose should be included in paragraph 5 a and b of the application form.

No new building construction may be undertaken under research grants.

Fellowships in Cancer Research of the American Cancer Society, administered by the Committee on Growth of the National Research Council, are offered for advanced training and experience in any field of investigation pertaining to the problem of cancer. The Committee on Growth welcomes the cooperation of universities and hospitals in making known the opportunities to suitable candidates. Two grades of fellowships have been established: Fellowships in Cancer Research and Senior Fellowships in Cancer Research.

Applicants must have the degree of Doctor of Medicine, Doctor of Philosophy or Doctor of Science. It is expected that transcripts of professional school records, recommendations from qualified scientists and two photographs will be furnished with the application.

It is the conviction of the Committee on Growth that the training and interest of young men in the many complex and difficult disciplines of modern scientific thought and technique are fundamental to a sound approach to the specific problem of human cancer. Therefore, fellowships have been made available for training in all branches of biological, chemical and physical sciences and of clinical investigative medicine. Candidates will be favored who express intention of following a career in a discipline susceptible of application to the study of growth in any of its aspects, typical or neoplastic.

Fellowships in Cancer Research are designed to provide opportunities for basic or clinical research under favorable conditions. Applicants must be able to demonstrate that they are qualified and fitted for scientific investigation. Candidates will be favored who desire to obtain thorough experience in one of the basic sciences. It is intended that this training

may lead to any field of research pertaining broadly to the problem of growth, normal or malignant.

The annual stipend will be determined by individual circumstances. The usual amount has been from $2,000 to $3,000 per annum. Fellowships are granted for one year but may be renewed upon application. With each fellowship award, an additional sum of $500 annually will be made available to the institution to defray laboratory expenses.

Senior fellowships, limited in number, are designed to provide an opportunity, under favorable conditions, for a prolonged period of advanced training in the field of growth. This study may be in the basic sciences or in clinical work or both.

Senior fellowships are intended for men or women who have already demonstrated unusual aptitude and promise of achievement in teaching and investigation. It is expected that they will have several publications in their field of research.

Original appointments will be made for a term of three years but may be renewed at the discretion of the Committee for an additional period not to exceed three years. The Committee reserves the right to convert applications for the Senior Fellowships into ordinary Fellowships according to its judgment of the applicant's qualifications.

The annual stipend will be determined by individual circumstances and by the cost of living in the location of study. The amount may vary from $3,000-$6,000. An annual sum of $1,000 granted to the institution for laboratory expenses will accompany the award of each Senior Fellowship.

Fellowships are subject to approval both by the Committee on Growth and by the Executive Committee of the American Cancer Society. Applications for fellowships effective during the ensuing year will be received until December 1 of the present year. Decision concerning awards ordinarily will be made early in February. While appointments may begin on any date determined by the Committee, it is intended that, as far as practicable, fellowships will start on July 1.

Cancer Detection Center Opened in Bridgeport

The Bridgeport Junior League has brought to a successful conclusion its two-year campaign to raise funds for the establishment of a cancer detection center.

In cooperation with the Connecticut Cancer Society, the detection center was recently established in downtown Bridgeport. It includes a reception room, doctor's consultation room, an office for the executive secretary, two examining rooms, four small dressing rooms, and a utility room. The paid staff includes ten part-time physicians, two registered nurses, and an executive secretary. A receptionist and several nurses' aides are working as volunteers. During the two-year campaign the League raised more than $6,000 to establish the center.

The following is reprinted from a recent issue of the British Medical Journal. *It may strike a responsive note on this side of the Atlantic.* [Ed.]

Intraprofessional Courtesy

It is a pleasant courtesy—but not a compulsory ethical requirement—whereby members of the medical profession refrain from charging a fee when attending another doctor or his family. We like to think that in the vast majority of cases the courtesy is appreciated, and, if opportunity arises, reciprocated. Sometimes the doctor who has performed the service is gratified to receive at Christmas a box of cigars or a book token. But from correspondence which has reached this office it appears that sometimes the courtesy is taken too much for granted. A radiologist who writes to us on the subject comments on the sad lack of manners displayed by some professional colleagues. Perhaps he has a special grievance, because, while in many cases the attendance given by a doctor to a colleague or his family may not involve him in actual out-of-pocket expenses, in the case of the radiologist, whose opinion has to be founded on the use of some rather expensive material and apparatus, it may mean, if the examination is elaborate, an expenditure of perhaps £3 or £4. Our correspondent says that he has carried out x-ray examinations on members of doctors' families, and has reported to another consultant, and sent copies of the report to the husband, sometimes making long-distance telephone calls; "but not one in twenty, if that, have expressed the slightest gratitude." This is a very discouraging testimony, and one can only hope that the experience is exceptional.

"DOCTOR'S ORDERS"

The Connecticut State Medical Society

on the Air

Every Sunday at 1:15 P. M.

Yankee Network

		Dial Settings
WICC	Bridgeport	600
WWCO	Waterbury	1240
WONS	Hartford	1410
WNLC	New London	1490

Schedule

January 18	Pneumonia
January 25	Coronary Thrombosis
February 1	Common Cold
February 8	Arthritis
February 15	Deafness
February 22	Eczema
February 29	Adolescence
March 7	Diabetes
March 14	Cerebral Palsy
March 21	Anemia
March 28	Neuroses
April 4	Hernia
April 11	Tonsillectomy
April 18	Spring Fever

AMA FIRST INTERIM SESSION, JANUARY 5-8, 1948

The recent meetings of the American Medical Association held in Cleveland—the first interim session—featured the general practitioner.

CONNECTICUT PHYSICIANS ATTENDING FIRST INTERIM SESSION

Creighton Barker, New Haven
R. F. Buchan, New Haven
Bernard S. Dignam, Thompsonville
Lyle G. Ellis, Hartford
John N. Gallivan, East Hartford
Albert S. Gray, Hartford
Joseph H. Howard, Bridgeport
K. T. Johnstone, Devon
J. Wister Meigs, New Haven
James R. Miller, Hartford
Thomas P. Murdock, Meriden
William T. Salter, New Haven
Frank D. Ursone, Norfolk
Stanley B. Weld, Hartford

GENERAL PRACTITIONER'S AWARD

Almost the first act of the House of Delegates was to select the recipient of the General Practitioner's Award. By an overwhelming vote made unanimous by acclamation the first award of this medal went to Archer C. Sudan of Kremmling, Colorado. Dr. Sudan has a long history of excellent service to the citizens of this village of slightly over 500 people and to the surrounding area within a radius of 80 miles. In 1926, on leave from the University of Chicago, Dr. Sudan was struck by the extreme need and complete lack of medical service in the town of Kremmling which he visited while on vacation. He requested a one year extension of his leave from the University and undertook practice in Kremmling. This one year became 21 years in a country where the winters are so severe he frequently was forced to journey long distances by bob sled. Dr. Sudan became mentor, counselor and consultant in all the problems of living to the villagers of Kremmling and the residents of Grand County. In 1946 he was elected president of the Colorado State Medical Society. He is an outstanding fisherman and hunter. The day following the action of the House of Delegates Dr. Sudan arrived in Cleveland by plane to accept the award at the evening session in the Cleveland Public Auditorium. In grasping the hand of this 200 odd pound physician and chatting with him one cannot help but be impressed by the wisdom of selecting him as America's outstanding general practitioner. The honor is well placed and Colorado medicine is to be congratulated on possessing suc a pillar of strength.

Coming at a busy time of year for the gener practitioner the registration of about 3,000 shoul be encouraging to the Board of Trustees and Hous of Delegates. Sessions of special groups were hel the Annual Congress on Industrial Health, the Gra Roots Conference of County Medical Societ Officers, the Midwest Regional Conference spor sored by the Council on Medical Service of th AMA, and many committee and council meeting The Board of Trustees met daily throughout th four days and on January 5 and 6 the House Delegates held an interim session.

SCIENTIFIC SESSIONS

Henry R. Viets of Boston and his Committee o Scientific Assembly arranged a two day progra designed to bring to the general practitioner th latest thought in many fields of medicine. There w a symposium on uterine hemorrhage, another o the treatment of pathologic disturbances of adole cence, one on multiple injuries in automobile acc dents, and two panel discussions covering care the posthospitalized diabetic patient. Music Hall the Cleveland Public Auditorium afforded an exce lent place for these sessions with good acoustic and ample seating space.

SCIENTIFIC EXHIBITS

The scientific exhibits were housed in the bas ment of Exhibition Hall and included, in additio clinics, demonstrations and movies. The Canc Detection Center was well set up and, as promise put through members of the Board of Trustees well as others who were anxious to learn first han how the Cleveland group carried on. Excelle clinical demonstrations for the general practition were conducted by the Cleveland Dermatologic Society and the American Diabetes Associatio Conservation of hearing for the particular benefit the general practitioner was demonstrated. Man excellent exhibits were set up affording the late knowledge of such subjects as the Rh Factor, Var cose Veins, Puerperal Sepsis, Chronic Shock, Infa tile Paralysis, Ununited Fractures of the Neck the Femur, Virus Pneumonia, Brucellosis, and th Fenestration Operation for Deafness. There we several exhibits demonstrating rehabilitation ar motion pictures closely related to the exhibits. Th

scientific exhibitors are due considerable credit for an excellent show well worth the time of every physician who could attend.

TECHNICAL EXHIBITS

On the main floor of the hall the various pharmaceutical houses, book companies, instrument dealers and food producers presented their wares. There was an opportunity for careful examination of every product at hand since at no time was the crowd too great or the atmosphere too close. New products appeared for the first time such as Connecticut's own Whirlpool Carriage for hydrotherapy and the new garter belt for pregnant women called Fancee-Free. Smith, Kline and French Laboratories again set up the Early American Apothecary Shop visited by thousands last summer at Atlantic City and filled with its aroma of myrrh. New gadgets were to be found on every hand and the many new books were offered for perusal. The Rexair dust remover appeared for the first time, and the National Institute of Diaper Services featured the new Ozinaire process of laundering and sterilizing.

GRASS ROOTS CONFERENCE

At the Second National Conference of County Medical Society Officers an attempt was made to answer three questions: (1) how to create more general practitioners for the future need of the country; (2) how to uphold the prestige of the general practitioner; and (3) how to get the general practitioner to assume community leadership. The solution of the first problem goes back to the medical schools and the discussion brought out the need for less emphasis on specialization and more on general practice at that level. The Michigan Medical Society has a plan in operation for financing the training of general practitioners. The Indiana Association offers scholarships for medical students who will on graduation spend five years practicing in rural areas. Some believe men should be permitted to enter medical school earlier, others that more well equipped small hospitals should be built to attract the general practitioner. The need for finding a place for the general practitioner on hospital staffs was stressed. Many participating in the discussion felt that the general practitioner need have no fear for his prestige but the chief problem seems to be the inability of many general practitioners to gain admission to hospital courtesy staffs, not to mention active staff appointments. Two hospitals in Michigan were cited where there exists a section for the general practitioners operating satisfactorily. San Francisco has one small hospital where every physician in attendance must be a general practitioner. A plea was made for more leadership by the general practitioner in community health and health legislation and in business, social, and religious groups.

HOUSE OF DELEGATES

Thanks to the appointment at the Atlantic Session last summer of a Committee to Expedite Work of the House of Delegates, the business at hand was cared for quickly and thoroughly. Connecticut was represented on the reference committees by our executive secretary who served as chairman of the Reference Committee on Medical Education and Hospitals. The chairman of our council, Thomas P. Murdock, rendered an excellent report of progress for his Committee to Study the Nursing Problem. In this report Dr. Murdock called attention to the fact that his committee had been concerned with three phases of the problem, immediate relief, future training courses for various grades of nurses, and economic conditions. The committee's recommendation was passed to the effect that there be a permanent conference committee of 5 members each from the American Medical Association, the American Nurses Association and the American Hospital Association.

The Board of Trustees reported a deficit for 1947 of $170,495 and a budget for 1948 over $100,000 more than the expected income. It was pointed out that, whereas in 1929 the *Journal of the AMA* averaging 128 pages cost 8.5 cents per copy to produce, in 1947 this cost had increased to 12.6 cents. It was voted to recommend to the Board of Trustees that the fellowship dues of the AMA be raised to $12 in 1948 to include subscription to the *Journal* and in subsequent years that these dues be not more than $12. A vote was passed that a special committee of 5 including 2 general practitioners be created to study the whole problem of intern placement. To this committee was referred a resolution pertaining to the assignment of interns to hospitals on the basis of bed capacity. This committee is to work with the Council on Medical Education and Hospitals in formulating a plan for the distribution of interns. To this Committee was also referred a resolution to study the problem of the regulation of the practice of pathology by regular and approved hospitals. The National Multiple Sclerosis Society was endorsed. The Board of Trustees was instructed to study and take suitable action on

propaganda being distributed to the armed forces. A resolution was passed implementing the work of case finding by an x-ray of the chest, affording this procedure to all school children and teachers. The House voted to request the U. S. Public Health Service and the immigration authorities to aid in preventing the introduction of tuberculosis and other communicable diseases into this country by requiring proper examinations in the country from which the immigrant should come and, if this is not done, at the port of entry.

A special committee previously appointed to study the problem of the relationship of hospitals to the practice of medicine submitted its report to the House of Delegates. The president of our State Society, Dr. Miller, was a member of this committee. The encroachment of hospitals on the practice of medicine should be of vital concern to every physician. The committee in its report pointed out that anesthesiology, radiology, physiotherapy, and pathology are medical specialties and as such should be represented on medical boards of hospitals. The House voted to accept the recommendation for the formation of a special committee to study all recommendations pertaining to this problem and report back at the annual session in June.

The delegates to the World Medical Association reported and were commended for their wisdom and foresight. New York City has been selected as the permanent headquarters of the Association.

A Section on Allergy and one on the History of Medicine of the AMA were approved. A Section on Legal Medicine was not approved but papers on this subject are to be included in the Section on General Medicine. An application for a Section on Physical Medicine was deferred pending changes to be made in the constitution and by-laws.

The Committee on Rural Medical Service submitted a report and distributed a printed handbook entitled "Extension of Rural Medical Service." This includes the annual reports of the various state committees on Rural Medical Service. Norman Gardner's excellent report from Connecticut appears along with those from the other states.

In executive session the House of Delegates dealt with differences which have arisen between policies of Associated Medical Care Plans, Inc., and the Council on Medical Service of the AMA. The former approves only voluntary non profit prepaid medical care plans; the latter believes all prepaid medical care plans meeting certain specifications should receive the official seal of approval. The House voted to concur in the opinion of the reference committee to which this matter was referred by upholding the stand of the Council on Medical Service. Dr. Paul Hawley has been secured to be the head of Associated Medical Care Plans and the Blue Cross Commission to advance the prepaid program in the various states.

In his message to the House, President Edward L. Bortz called attention to Connecticut's excellent arrangements for student membership. He emphasized that the radioactive isotopes constitute the most important development in medicine since the microscope, as pointed out by Shields Warren, medical consultant of the Atomic Energy Commission.

One becomes increasingly impressed with the seriousness with which the House of Delegates carries out its duties. The first interim session of the AMA was not the first time the House had met between annual meetings. There is no question that the general practitioner ascended to a place of prominence at this session. It afforded opportunity for a discussion of many of the burning problems of medical practice which affect the general practitioner, the specialist and the hospital. From this session should come repercussions in every State in the Union. Such makes for progress.

AMA Replies to the President

Dr. E. L. Henderson of Louisville, Ky., speaking on behalf of the officers and the Board of Trustees of the American Medical Association as chairman, made the following comment January 8 upon President Truman's proposed expansion of federal health program in his State of the Union message. Dr. Henderson's statement was issued while the AMA representing 137,000 physicians and surgeons, was meeting in Cleveland in Interim Session:

"The ideals of freedom which the President mentioned in reference to health find their greatest expression when the medical service needs of the American people are met on a local community and state basis. The American Medical Association is effecting this program through its own 10-point National Health Program.

"The Association is encouraging the enrollment of all persons in the United States in community sponsored plans for prepaying hospital and doctor bills.

"Already 29,000,000 Americans are protected against the costs of hospitalization through the Blue Cross. These plans are available to the citizens of 49 of our 49 states and in the District of Columbia.

"Prepayment of doctor bills in medical society approved plans are now operating in 38 states, and in the 10 remaining states and the District of Columbia, similar plans for paying doctor bills by budgeting in advance are being developed. Enrollment in these plans are in the millions.

"Additional millions are budgeting their hospital and doctor bills through group and individual policies in long established and financially proven private insurance companies.

"These voluntary approaches to solving America's health problem have taken us far on the way toward meeting the President's standard of 'a national system of payment for medical care based on well tried insurance principles.'

"The American Medical Association has fully approved grants-in-aid to states to aid in paying for hospital and doctor care for the medically indigent. It is our belief that the great bulk of America's 140,000,000 people will continue to take care of their own needs as they have always done in a voluntary way.

"The American Medical Association agrees with the President that our great nation should not allow its citizens to suffer needlessly from the lack of proper medical care. Through its National Health Program the American Medical Association is furthering the advancement of medical science through research, extending medical care to rural areas, improving industrial health, bettering medical education, expanding preventive medical services, providing increased pre-natal, child, and mother care, and fostering construction of new hospitals and health centers.

"We are proud of the President's acknowledgment of the remarkable contribution made to date to the nation's health by the medical profession when he said: 'We are rightly proud of the high standards of medical care we know how to provide in the United States.'

"In cooperation with local leaders everywhere the medical profession will continue to strive to raise still further the level of medical care, promote its widest distribution and to aid the people in meeting conveniently its costs."

AMA News

The Board of Trustees, meeting at AMA headquarters recently, took the following action:

Dr. James A. Waring, Denver, was appointed to the Council on Medical Education and Hospitals to replace Dr. John Musser, who passed away recently.

Drs. Wingate Johnson, Winston-Salem, N. C., and James R. Miller, Hartford, Conn., members of the Board of Trustees, were elected to represent the AMA at the White House Conference on Family Life to be held in May 1948.

The Bureau of Information has been absorbed by the Council on Medical Service.

At the request of the American School Health Association, Dr. Dean F. Smiley of the Bureau of Health Education has been appointed as a representative of the AMA on the governing council of that organization.

Drs. Oscar Hunter and Eugene R. Whitmore, Washington, D. C., were appointed to represent the AMA at the Fourth International Congress of Tropical Medicine.

The Committee on American Health Resorts is to be discontinued, effective December 31, 1947.

The Board of Trustees has approved the appointment of Dr. James C. Sargent, Milwaukee, Wis., as chairman of the Council on National Emergency Medical Service. Dr. Richard L. Meiling, Columbus, Ohio, is secretary of the council, and Frances Tofield, Chicago, executive secretary. Members of the council are: Drs. Winchell M. Craig, Rochester, Minn.; Harold S. Diehl, University of Minnesota, Minneapolis; Perrin H. Long, Baltimore; Harold C. Lueth, University of Nebraska, Omaha, and Stafford L. Warren, University of California, Los Angeles. President Edward L. Bortz, Philadelphia, and Secretary George F. Lull are the ex officio members, representing the AMA.

NEW AMA HANDBOOK

A new handbook summarizing the functions of each of the councils, bureaus and key departments of the American Medical Association is now being printed. The publication is primarily for physicians and was written to provide information and services which the association is prepared to offer its members. Copies are available on request.

PHARMACISTS HONOR AMA

On December 16 the ninth annual scientific award of the American Pharmaceutical Manufacturers'

Association was presented to the American Medical Association in recognition of its fundamental contributions to public health in the field of medical research. The presentation was made on the second day of the midyear meeting of the American Pharmaceutical Maunfacturers' Association which was held at the Waldorf-Astoria Hotel, New York City, on December 15, 16 and 17.

AMA BOARD OF TRUSTEES SETS UP ADVISORY LEGISLATIVE COMMITTEE

The Board of Trustees, at the request of the Council on Medical Service, appointed the following to compose a *special advisory committee on legislation:* Dr. Elmer L. Henderson; Dr. Ernest E. Irons, Dr. Louis H. Bauer, Dr. William F. Braasch, Dr. James R. McVay, Dr. Morris Fishbein, and Dr. George F. Lull. The Washington Office will send to all members of this committee copies of bills and resolutions dealing with medicine and public health as they appear in the two Houses. After a careful study of each bill, the committee will advise the Washington office as to whether the bill can be appproved or not. The substance of these instructions will be published in the Bulletin. This committee will not make decisions with regard to policy, but give directions in accordance with past actions of the House of Delegates.

BROCHURE ON MEDICAL CARE PREPAYMENT PLANS

The Council on Medical Service of the American Medical Association has just published a brochure entitled "Medical Care Prepayment Plan Development Through a Local Health Council."

This brochure covers the important subject of a local health council, its organization and functions, and points to the fact that such a council should be sponsored by the county medical society. Suggestions for the development of a local health services program through such a council are directed largely toward areas other than our larger cities.

Development of voluntary prepayment medical care as part of such a council's activities is discussed as well as rural community enrollment through committees of the council.

L. S. Kleinschmidt of the Council on Medical Service, in developing the suggestions presented in the brochure, reviewed the progress of sixteen medical care plans and studied the methods used by nine of them. The studies of local health councils and rural community enrollment in voluntary medical care plans are being continued for the purpose of obtaining detailed information on various suggestions in order to assist local health councils in developing their program step by step.

AMA PUBLIC RELATIONS APPOINTMENTS

Dr. George F. Lull, secretary and general manager of the American Medical Association, announced recently the appointment of Lawrence W. Rember as his executive assistant in charge of public relations.

Mr. Rember, who fills a post vacated by the resignation last June of Charles M. Swart, will take up his new duties on December 16.

At the same time, Dr. Lull announced the appointment of the Chicago firm of Theodore R. Sills & Company as public relations counsel for the American Medical Association.

Mr. Rember gained his experience in the health and public service fields as director of public relations for the Blue Cross Plan Commission of the American Hospital Association and as public relations director of the midwestern area of 17 states of the American National Red Cross.

Mr. Rember has served as assistant general manager of the public relations nutrition research agency of the poultry and egg industry, representing 28 national and regional trade associations. He received his master's degree from the Medill School of Journalism at Northwestern University and his Bachelor of Arts degree from the University of Wisconsin, where he specialized in journalism and commerce. He supplemented this education by teaching journalism and advertising at the Henry W. Grady School of Journalism, University of Georgia.

A member of the National Association of Public Relations Counsel and a director of its Chicago chapter, Mr. Rember is also secretary-treasurer of the association and writer of its official publication.

DR. W. W. BAUER RECEIVES AWARD

W. W. Bauer, M.D., director of the Bureau of Health Education of the American Medical Association since 1932, has been awarded the Elisabeth Severance Prentiss National Award in Health Education, given each year by the Cleveland Health Museum to the person who has made the most outstanding contribution to health education. Since the Museum was opened in 1940, Dr. Bauer and his associates have personally answered 3,500 questions dropped into the Museum Question Box by visitors seeking health information. Established in 1943, in

effort to encourage outstanding work in the field health education, the award also serves to honor e memory of the Museum's first foundation benector, Elisabeth Severance Prentiss.

The Cleveland Health Museum, incorporated in 936 and opened in 1940, is an unique health education institution. The *First Health Museum in merica*, it is designed especially for introducing an to himself. It has as its main objective the dismination of "Health Education" to all peoples. luseum facilities, such as three dimensional exhibits which invite visitor participation in ringing bells, ushing buttons, pulling levers, turning handles, d whirling knobs), films, pictures, etc., are availle for loan. Each year visitors come from all parts the world. Bruno Gebhard, M.D., museum director, is the former curator of the Dresden (Germany) ealth Museum.

Among the former Prentiss Award winners is .-E. A. Winslow, professor emeritus of public ealth at Yale.

New Pharmaceutical-Medical Research Foundation

The recently formed Pharmaceutical-Medical esearch Foundation plans to make extensive studies lating to the chemical and physical changes that cur in tissues and to the physiology of the body, rticularly concerning substances taken into the dy and their ultimate fate. A committee including presentatives of the pharmaceutical industry and e medical profession was organized to establish e new foundation.

merican College of Physicians Research Fellowships in Medicine 1948 Awards

The Board of Regents of the College, on the omination of the Committee on Fellowships and wards, awarded six Research Fellowships in ledicine for the year beginning July, 1948, at their eetings in Philadelphia on November 22 and 23, 947. The awards were made to the following hysicians: Charles Gordon Campbell, M.D., C.M., ancouver, B. C., Canada; Frank Herbert Gardner, .D., San Bernardino, California; Samuel P. Martin, .D., Durham, North Carolina; Peritz Scheinberg, .D., Miami, Florida; Lutfu Larut Uzman, M.D., tanbul, Turkey; and John Martin Weller, M.D., nn Arbor, Michigan.

Chloroform Anesthesia Centenary

Ceremonies were held in Edinburgh, Scotland, on November 4, 1947 to commemorate the centenary of Sir James Young Simpson's discovery of chloroform anesthesia. In addition to the presentation of several scientific papers, a reception was held at which Dr. Douglas Guthrie gave a brief and interesting address on the life and work of Sir James Simpson. Some personal relics were shown, together with items of historical and technical interest in connection with the development of anesthetics. Dr. John Fulton, chairman of the department of physiology at Yale University School of Medicine, flew to Scotland to attend the centenary.

The "Normal" Female Pelvis

Nutrition Reviews for November 1947 contains a discussion of the "Role of Nutrition in Pelvic Variation" in which it is suggested that the so-called normal female pelvis or oval type in reality may be abnormal. It raises the question propounded by Herbert Thoms in a recent issue of the *American Journal of Obstetrics* of whether this type of pelvis may be the consequence of certain deficiencies in nutrition, especially during the puberal period when nutritional requirements are in more delicate balance than at other periods of growth and when the storage of calcium is an important factor and the requirement for vitamin D is great.

Delay in Screening Cancer Cases

From the chairman of the Nassau County (N. Y.) Cancer Committee comes the frank statement that "the initial 'screening' to disclose suspicion of disease can be done effectively and much more promptly by a competent and conscientious general practitioner than by an overworked specialist in an overcrowded 'clinic'." Because of the limited number of specialists the person to be examined in a clinic may have to make an appointment weeks or months in advance. The same writer informs us that many of the newly established cancer detection clinics are booked up months in advance and because of the delay in a necessary examination these clinics cannot solve the problem.

The general practitioner is looking for a place under the sun in this day of specialization. Here is a renewal of the old challenge for a thorough examination of his patient. The general practitioner must not overlook this obligation.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

State Medical Societies Criticize VA

So critical were some of the reports brought in to the recent Conference on the Veterans Administration Home Town Medical Care Program held in Chicago that the delegates sat in executive session. This accounts for the delay in reporting the results of this Conference to our readers. The conference was sponsored by the Council on Medical Service of the AMA which, late in December 1947, issued a 24 page report of the discussions and conclusions.

To the conference were brought through formal papers the experiences of the North Central States, of Michigan, Kansas, California, and the Rocky Mountain States. Some of the speakers were extremely critical of the attitude of VA's branch and regional offices, of the change in fee schedules which had been presented in good faith by state medical societies, of the breakdown in the establishment of home town medical care in the larger urban centers. The experience of Michigan with VA seemed to be the most satisfactory, possibly because Michigan was aggressive in establishing a program, setting up its own rules of the game, and carrying the ball itself most of the time.

Kansas reported very favorably on its experience with a medical coordinator. Also, in spite of many difficulties in carrying out the Home Town Care program, success of the program is attributed to the "finest kind of cooperation imaginable received from General Hawley and Colonel Harding."

Here is a summary of the Conference:

Following an address by Dr. Paul R. Hawley the Conference was turned over to a round table discussion under the leadership of James R. McVay, M.D. The discussants included those who had addressed the Conference and John C. Harding, M.D., assistant medical director for Auxiliary Services, VA.

Several representatives addressed inquiries to the discussants in an effort to learn why the program was not functioning more smoothly in particular areas. Many representatives expressed the feeling that their own programs would be more satisfactory to the veterans and the medical profession if the employees in regional and branch offices had the "Hawley philosophy." Dr. Hawley asked to be advised of specific administrative difficulties so that proper solutions could be attempted.

The future intent of the VA and its plans for more and expanded VA facilities created general interest. Many expressed the fear that the creation of new facilities and the expansion of existing facilities might result in the abandonment of the "Home Town" program. At this point, Dr. Hawley pointed out that the establishment of clinics had not kept pace with the case load. After the first World War there were approximately four million veterans and a total of fifty-one clinics were created to care for this load. At the close of World War II, there were approximately eighteen million veterans and there are now only seventy clinics. Interpreting this in the number of veterans per clinic, the original ratio was one clinic for each 127,000 veterans while now there are about 339,000 veterans for each clinic.

When asked why new VA facilities were being constructed in areas where other hospitals were already in existence, it was disclosed that in some instances the already existing units were Army units and that these could not be depended upon by the Veterans Administration.

As to the future of the program providing medical care to veterans by doctors of the veterans' choice, it was conceded that the answer lay in the number of satisfied veterans and the extent to which this satisfaction is expressed in their future voting.

Originally the facilities of the VA were to be utilized only by veterans who could prove service connected disabilities. Now both service connected and non service connected cases are treated, provided beds are available. Since these services were extended by an act of Congress, the VA could not assume responsibility for extension.

It was suggested from the floor that the AMA Committee on Veterans Affairs might meet in Washington with Dr. Hawley and the Medical Advisory

Group of the VA to establish policy with regard to he Home Town Medical Care Program.

This suggestion was welcomed, and Dr. Hawley ndicated he would advise the AMA Committee of he date of the next meeting of the Medical Ad- isory Group and extended an invitation to the AMA Committee to attend.

It was concluded that states having specific prob- ems or suggestions regarding policy might refer hem to the AMA Committee on Veterans Affairs. This Committee could then act as a clearing house nd, if necessary, carry the problems and suggestions irectly to the Veterans Administration in Wash- ngton.

A special committee was appointed by the chair- nan of the Conference to confer with the AMA Committee on Veterans Affairs. It was suggested hat this committee could epitomize the papers and iscussions of the Conference and assist the AMA Committee in securing a cross section of opinions. Dr. Barker, executive secretary of this Society, was ppointed to this committee.

VA Training Course in Artificial Limb Mechanics

The Veterans Administration have conducted a raining course at VA headquarters in New York, or one week beginning December 8 and ended December 13.

The school was held to train artificial limb nechanics to make and fit the new National Suction ocket for amputees with above knee amputations.

The experienced fitters who have made and fitted suction socket successfully to a veteran at the chool will receive a Certificate of Approval from ne government, and the Veterans Administration t Hartford and other parts of the country will be otified and suction socket artificial limbs will only e purchased from concerns who have been ap- roved and have government contracts.

Schools were also held for doctors in various arts of the country in order for them to select uitable amputees for the suction socket. This new ype socket eliminates all body-belts and supporting traps and can only be used for selected, suitable ases.

Joseph A. Ganzke, proprietor of the New Haven rtificial Limb Co., 805 Congress Avenue, New Haven, has attended the entire course.

The suction socket will be released and purchased ommercially from approved firms after February 1.

This is the first time in history that the govern- ment, industry and the orthopedic surgeons have merged their plans, personnel and money to train an entire industry. It is being done for the benefit of the amputees.

The End of Prima Facie Evidence

Veterans Administration has announced that prima facie evidence will not be accepted as suffi- cient proof for veterans to establish service connec- tion for medical and dental treatment after Decem- ber 31, 1947. Veterans have had a full year after the President announced the end of hostilities in which to secure treatment on the presumption of service connection, based on prima facie evidence.

VA takes the position that this should have been ample time for emergency or clearly defined service connected cases to have received treatment.

The discontinuance of determination on prima facie evidence in no way denies veterans any rights they are granted by law, nor does it limit services given those whose conditions are rated as service connected.

Applications for treatment received or mailed after December 31 will have to be formally adjudi- cated under the Regulations before treatment other than emergency can be given.

This ruling in no way affects the year's presump- tion of service connection to which all veterans are entitled after discharge.

Appointment of Commissioned Officers in the Medical Corps and Dental Corps of the Regular Navy

The statutory authority contained in Public Law 365—80th Congress, Title II (Army-Navy-Public Health Service Medical Officer Procurement Act of 1947) makes it possible now for civilian doctors to become commissioned officers in the regular Navy, provided they meet the professional and physical qualifications. This law is unique in that it does away with, for the first time, the age limitation of thirty- two years of age and permits doctors in civilian practice to enter the Navy and be commissioned with the rank up to and including Captain. The law considers all strata of the medical profession, interns, residents, reserves, former medical officers who have resigned, and present practicing physi- cians.

In order to make application a doctor must be a citizen of the United States, a graduate from a Class "A" medical school and have served at least one year's internship in an approved hospital. Candidates will then be judged on a number of qualifications such as being a member of a specialty board, his teaching connections, the number of years of professional or scientific practice, hospital or laboratory connections, a statement of military service, etc.

The allocation of rank to successful candidates will depend upon their academic age, professional standing, and experience in the medical field. Successful candidates will then be integrated in line with medical officers of the regular Navy and assigned running mates accordingly. This means that they will be eligible for promotion along with their fellow officers of equal rank.

This law offers a fine opportunity for civilian doctors to make a career in the regular Navy and to enjoy its professional advantages as well as its retirement benefits. Doctors interested in such a career should write to the Bureau of Naval Personnel, via the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

Non Service Disabilities Treated Only In VA Hospitals

Veterans cannot receive treatment for non service connected disabilities in VA outpatient clinics or from physicians and dentists enrolled in the Home-Town Medical Care Plan, according to a recent announcement by Harry T. Wood, manager of the Hartford Regional Office of the Veterans Administration.

A veteran may, however, get treatment in a VA hospital for a non service connected disability if a bed is available and if he signs a statement that he cannot afford treatment elsewhere, according to the bulletin. Veterans with service connected disabilities have priority for hospital beds.

Veterans with non service connected disabilities who desire hospitalization and treatment in a VA hospital may apply at their local VA office.

Rehabilitation of Deaf

Development of a program to rehabilitate more than 1500 Connecticut veterans suffering from hearing defects is being accelerated by the Hartford Regional Office of the Veterans Administration, according to an announcement by Harry T Wood, Manager.

Using skills and techniques developed in specialized service units during the war, VA personne trained in aural rehabilitation and consultant professional specialists are establishing a program designed to assist the deafened veteran adjust himself socially and vocationally to his hearing handicap

In cooperation with the Connecticut League fo the Hard of Hearing, lip reading classes have beer instituted in Hartford, Waterbury, Bridgeport and New Haven. Medical specialists are being called in for consultations when ear diseases are evident, and where individual cases require special treatment.

Advertising Bureau Growing

The Cooperative Medical Advertising Bureau i now operating with a membership of thirty-three state medical journals representing forty-one state medical societies. The Montana State Medical Society is now being represented through the *Rocky Mountain Medical Journal.*

The bureau's entire revenue from advertising i turned over to member journals. This exceeds an annual net billing of $625,000 as compared with $457,000 in 1945 and $307,577 in 1944. Less than five per cent of the current year's billing is required to maintain the bureau's budget.

Since the bureau was reorganized in Decembe 1945, progress has been made in every phase of it service to the journals. A bulletin is issued each month and this contains pertinent facts for improvement of advertising make-up. Products currently accepted by the various councils of the AMA are listed for guidance in maintaining the same advertising standards as those which apply to the *Journa of the AMA.*

The bureau renders complete service to Journa members in securing advertising space sales, copy instructions and plates. It also reviews advertising copy before publication, which is an important factor in maintaining the high standards provided in the revised operative principles.

The editor of the CONNECTICUT STATE MEDICAL JOURNAL is chairman of the Advisory Committee o the Bureau.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Richard H. Grant, Cromwell
New London County, Edmund L. Douglass, *Chairman*
Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, Leonard W. Levine, Ellington
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

NEWS FROM WASHINGTON

With the conventions of both major political parties still several months in the offing, prospective presidential candidates on both sides are already "talking up" their programs for the extension of medical care.

The health programs, discussed at length in newspapers and magazines, vary from support of the Wagner-Murray-Dingell bill and the Taft-Smith-Ball-Donnell bill to a variety of programs for grants-in-aid and building of new hospital facilities.

It seems that since the health football is being tossed far and wide on political fields so early in the campaigns, the pressure eventually will be directed to the platform committees of the major parties. The decisions, therefore, will likely come from these committees. If Taft should continue his present stand the younger Republicans may take the ball from him. They sense the feeling of the people with respect to their attempts to live within the purchasing power of their 50-cent dollar and might easily rally to Truman as their political savior.

Oscar Ewing, the new Administrator of Social Security, met with state and territorial heads of U. S. Public Health Service on December 1. This talk was his first made to Public Health Service. Mr. Ewing expressed a novel slant for a bureaucrat when he told the Conference that, while he favored National Health Insurance, it was not the present solution to the problem of the nation's health. Relief and research in cardiac diseases, cancer and mental illness, housing, sanitation, nutrition and water purification are problems that can and should receive immediate attention. By this talk it would seem Mr. Ewing at least has a different point of view than some of his predecessors. It would seem to some that he is preparing for the great day when he will become Secretary of Health, Education, and Security. Members of his staff are being moved into new positions. A nationwide publicity program has been launched to sing the praises of Federal Security Agency on the air. The President, it is said, has promised the Cabinet post to Ewing as a political plum. The Republicans have held hearings on S140 and S712, both calling for creation of the new Department, and a favorable report has been presented to the Senate by the Committee on Expenditures, of which Senator Aiken is chairman. Ewing says he *has* to have a tripartite Department; the President asserts there shall be such a Department; and the Republicans sponsor legislation that would create the Department. That appears to make it unanimous. The new S140 as reported fails to call for a doctor of medicine in the position of Under Secretary for Health. Thus the FSA forces won out in the battle over S140. The revised bill is almost certain to come to a vote during the next session.

Dr. Miller, Congressman from Nebraska, seems to think Republican are increasing in the House who wish Federal aid for the nation's health, such as Senator Taft's bill proposes. Senator Smith, chairman of the Senate Subcommittee hearing S545 and S1320, has written to all State Governors asking them if they would favor a state experiment in Compulsory Health Insurance. The Senator will include a report on this inquiry in a statement to be made later.

Hearings were expected to be resumed in January on S545 and S1320. There is talk of a compromise for a bill to extend disability and sickness insurance nationally. Politics.

HR4816 was introduced by Mr. Bartlett of Alaska on December 19, 1947. It is a bill to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $250,000 to each State

for the construction of hospitals. It has been referred to the Committee on Interstate and Foreign Commerce.

This bill seeks to amend the formula and increase the authorization in the Hospital Survey and Construction Act (Public Law 725) to provide a minimum allotment to each State of $250,000 per annum. A resolution was adopted at the 46th annual conference of the State and Territorial Health Officers, requesting that the Congress make such an amendment because under the present provisions of the law, several States receive allotments of a size insufficient to undertake basic programs. If this bill were to become a law, the following states and territories would be eligible for increased subsidy: Alaska, Delaware, Hawaii, Montana, Nevada, Vermont, and Wyoming.

Governors Thomas E. Dewey of New York; Alfred E. Driscoll of New Jersey; and James L. McConaughy of Connecticut; met December 18, 1947 at the Roosevelt Hotel to exchange views on the possibility of eliminating duplication of taxing fields by the Federal and state governments, adding sickness compensation to the social security structure and increasing unemployment insurance and workmen's compensation benefits. No attempt was made to arrive at final conclusions, but the subject matters may be material for future legislative enactments. Last year Governor Driscoll had urged a sickness compensation program, but failed to get legislative approval. A similar program was urged by the State Federation of Labor, in New York State, but failed in the legislature.

The United Mine Workers Union has employed Dr. Roy R. Sayers, who was director of the U. S. Bureau of Mines, as medical director to develop a program of medical care among the members of that union—to be financed from the fund which is being collected by means of a 10-cent-per-ton royalty on coal mined by the union workers. Dr. Sayers has a broad vision of his work and is developing a very comprehensive program. He already has a staff of 10 or more capable and experienced men. Dr. Carl Peterson, the executive secretary of our Industrial Council, is devoting a part of his time to helping Dr. Sayers.

Federal Security Agency's Combined Hospital-Medical Service Plan

Louis S. Reed, PH.D., of the Federal Security Agency in Washington in a 323 page survey report sets up sound actuarial reasons for merger of hos pital and medical service plans into a consolidate Blue Cross health service plan. Dr. Reed also mak an excellent case against present limitations c voluntary health plans, and he very cleverly sug gests that the best way to eliminate inevitable bank ruptcy is to guarantee more liberal benefits b having a national pool of reserves. One Washingto physician thinks this is just another way of sayin that if the risk and costs were nationalized, sub scriber costs would be lowered and adequate healt security insurance would be available to all withou economic, geographic or racial discrimination.

National Cancer Institute Grants

Award of nearly $750,000 in National Cance Institute grants was announced in a report mad public in December 1947 by Dr. Thomas Parra Surgeon General of the U. S. Public Health Servic Altogether 46 grants for clinical as well as basi biological research were given. The grants wer made on the recommendation of the National Ad visory Cancer Council, composed of outstandin cancer specialists from various sections of th country.

For the first time in the history of the Counci which has been making recommendations for te years, grants were given to scientists working out side this country. The two recipients were Dr. A Lacassagne of the Institute Pasteur in Paris, wh received $13,380, and Dr. L. Doljanski of Hebrew University in Palestine, who received $10,000.

The National Advisory Cancer Council als recommended $16,482 to the Connecticut Stat Department of Health for "analysis of data avail able in records of 37,833 cases of cancer."

Anti-Rh Serum Available Commercially

The development by Dr. Philip Levine, one o the world's outstanding serologists, of a highl accurate diagnostic anti-Rh (anti-D) serum derive from human blood has been announced by the Orth Pharmaceutical Corporation of Raritan, N. J., th first of the pharmaceutical houses to offer this typ of serum for determining whether an individual ha Rh negative or positive blood. It is now availabl for use by hospital and clinical laboratories to pre vent intragroup transfusion accidents and for th selection of Rh negative blood for the affected in fants of Rh negative mothers.

PROCEEDINGS — SEMI-ANNUAL MEETING HOUSE OF DELEGATES

New Haven Medical Association, New Haven, Connecticut, December 4, 1947

The Semi-Annual Meeting of the House of Delegates of e Connecticut State Medical Society was held at at the ew Haven Medical Association, 364 Whitney Avenue, ew Haven, Thursday. December 4, 1947, at 3:35 P. M. The eeting was called to order by President James R. Miller. Secretary Barker called the roll and a quorum was de- ired present.

President Miller: The first order of business is the con- leration of the budget for 1948 and the fixing of the nual membership dues, The budget will be presented by e treasurer.

Treasurer Gibson: Mr. President, Members of the House Delegates: As a part of the agenda which has been fur- shed you, you will notice on the second page the recom- ended budget, made on the recommendation of the coun- , with a total income stated at $65,700, and expenditures talling $64,755.* Since you have those figures in front of u, it won't be necessary, I think, to read them. But if you ve any questions, I would be glad to try to answer them.

Dr. Buckhout: The estimated income from the Journal, that for advertising only or is that for a certain allotment m each dues payer out of the $20 paid?

Treasurer Gibson: Advertising. Are there any other ques- ns?

Dr. Moorad: I would like to ask if the building and other l estate held by this society is free from taxation; and if , why is there an item of tax appearing on the bottom of e page?

Treasurer Gibson: There is an item of maintenance there, ctor. There is also an item of insurance included in that, bility insurance.

President Miller: The question has not yet been answered out the taxes.

Secretary Barker: We are charged real estate taxes, and e item of $500 included in the budget is for taxes and intenance. It includes $378 as the taxes, I believe.

Treasurer Gibson. $388 for taxes.

Secretary Barker: Real estate taxes to the city. We have ver filed a claim for tax exemption on property taxes. is building may give you a fair estimate of what the pro- dure would be. This building is owned by a similar ganization, and it is not tax free. It was battled through e Board of Assessors, or whoever it is, the Tax Commis- ner of the City of New Haven, a number of years ago d tax exemption was not allowed.

President Miller: Are there any other questions?

The motion was then carried to adopt the budget and to y an assessment of $20 a year for the coming year.

The next item is on the amendments to the by-laws. Will e secretary please present these amendments? These endments* were then approved as recommended by the uncil.

President Miller: I will ask the chairman of the Council, . Murdock, to take the chair.

*See January Journal, page 60.

Dr. Murdock came forward and assumed the chair.

Chairman Murdock: The next item on the agenda is the report of the President.

President Miller: Mr. Chairman, and Members of the House: It is customary at the annual meeting for the president to make a review of the condition of the Society; at the semi-annual meeting that we have had before that custom has been extended. During the past year I have been allowed the courtesy of expressing myself through the pages of the Journal each month, what has been on my mind at that particular time. I can assure you that if nothing is on my mind that I consider worth saying there will be no President's Page that month, for I think that paper and printing are too valuable to waste that way. I can really say at this time that the condition of the Society is sound. We have an agenda this afternoon which indicates that we are interested in action, and not in historical reviews, such as I might give. I want to call your attention to the mid-year meeting of the American Medical Association, which will be held from the 5th to the 8th of January, in Cleveland. The mid-year meetings of the American Medical Association are taking on a new form. The House of Delegates has found it necessary to meet twice a year, just as we have in this state, to transact the increasing business which descends on us. And in the mid-year meetings of the American Medical Association, the plan is to have the mid-year meetings of the House of Delegates held at different places year after year, so that the parent organization will be brought more closely in touch with the profession in all parts of the country.

At this mid-year meeting it is intended to focus the interest about the problems and interests of the general practitioner. Those of you who may, from time to time, be wearied with the exhaltation complexes of the specialist, I am sure, will find ample reward if you go to Cleveland. At the meeting in Cleveland, among the exhibits, there is to be one of a cancer detection center, put on and operated by the local division of the cancer society, at which physicians are to be offered the privilege of themselves being examined by this technique. The president of the American Medical Association and the three members of the board who are on that exhibit committee are all subjecting themselves to this experience. I personally would like to see what this examination is like from the point of view of a patient.

There is to be determined, also, the general practitioner who is thought to be conspicuous for his contribution to community life as a general practitioner, and a medal will be presented to that person. The process of nomination has been worked out with care. Nominations arise wherever they may, and are forwarded to the office in Chicago. They are submitted to the scrutiny of the executive committee of the Section on General Practice, which trims down the list, presents it to the Board of Trustees, which further prunes it down, and presents three names to the House of Delegates which will be voted on exactly as is the candi-

*See January Journal, page 60.

date for the Distinguished Service Medal at the annual meeting. This should be an interesting occasion.

The agenda is before you, and I want to take this opportunity to tell you how much I appreciate the privilege of working with you and for you. Thank you.

The president's report was unanimously accepted.

Chairman Murdock stepped down, and President Miller assumed the chair.

President Miller: The next item is the report of the Chairman of the Council, Dr. Murdock.

Dr. Murdock read his report* which was accepted as read.

President Miller: I will next call on the secretary for his report.

Secretary Barker read his report.† This was accepted as read.

President Miller: I call your attention to a visitor whom we have with us, Mr. John Farrell, executive secretary of the Rhode Island State Medical Society. He is going to be with us this afternoon and this evening, and you may have occasion to visit with him and ask him questions about similar questions in Rhode Island. Johnny, stand up and take a bow.

Applause as Dr. Farrell rose.

President Miller: Dr. Barker, you have another memorandum?

Secretary Barker: Mr. President, this is a report of the Conference Committee, the Joint Conference Committee of the Connecticut State Medical Society, and the Connecticut Pharmaceutical Association, submitted by Dr. Salter, the chairman of the committee. He has asked me to present it.

Secretary Barker read the report of the Joint Conference Committee.**

Secretary Barker: Dr. Salter also wished me to present to the House a statement with regard to use of prescription blanks bearing the names of pharmacists.

Dr. Barker read the statement†† which was received and placed on file.

President Miller: I will ask Dr. Murdock, chairman of the council, if he will take the chair, please.

Dr. Murdock came forward and assumed the chair.

Chairman Murdock: Next on the agenda is the report of the Committee on Prepaid Medical Care, of which Dr. Miller is the chairman.***

Dr. Miller: Mr. Chairman, the report of this committee has been circulated to all members of the house, and I would place it before you as presented. I will be glad to read it if it is so desired. If it be the wish of any member that this report be read, I can do so. It is not necessary to read the objectives and everything, but it can be read, if you wish.

Chairman Murdock: What is the wish of the House on the request of Dr. Miller? Is it your wish to have him read it or do you wish to pick out some certain parts of it for discussion?

Dr. Watson: I move that the reading of it be withhel

The motion was seconded.

Chairman Murdock: It is moved and seconded that tl reading of it be withheld, and the floor will be throw open for discussion and questions. Those in favor will signif in the usual manner. Opposed? So ordered.

I might suggest, Dr. Miller, that you pick out any phas that you think are important, and we can go on from ther

Dr. Miller: I would like to say something first about th publicity that came out. Seeing that no action had been take and the matter had not been presented to the House Delegates, it was my thought that publicity from the Soc ety's Office should not be indulged in. The publicity th did get out was not of my seeking. It was one of thos occasions in which the active reporter got wind of wh was brewing, and I had to make a quick decision as t whether he was going to get most of it straight, or go o his own, and we would take the consequences.

For good or ill, I sought to instruct him as best I coul and I think that if you will read the publicity you wi agree that perhaps 85 per cent of it was correct; not all it, of course. I personally think that the most importan part of this whole program is that it be understood an accepted by the profession. And in so far as this prematu publicity has served to awaken the interest, the acute inte est of the profession, I am rather glad that it took place.

We are too acquainted with the habit of physicians leading a routine report and not paying attention to until they are seated in the House of Delegates. That is n the condition at the present time. I think that every membe here is pretty well acquainted with the situation. There fore, I would present this report. It has been read to th council and has been authorized to be presented by th council, to the House. I would present it for as speed action as is consistent with the thorough understanding an support of the profession and the membership throughou the state.

Dr. Creadick: Schedule A, paragraph (5), is a new ap proach. Who interprets the income of the beneficiary?

President Miller: Dr. Creadick has put his finger upo the most important section of this whole program, that i the income level below which physicians undertake certai obligations for the public. If anyone can devise a metho by which the income of people can be determined, w would be glad to know it. The whole program leaves u exactly as we are today. The doctor sits across the des from the individual patient and comes to an agreement con cerning the fee. There is no interpolation of a third party There is no bureau down the street where a blue ticke or green ticket is issued, saying that this person is or i not above or below the income level.

It is entirely flexible, exactly as it is at the present time Those are the instructions we received one year ago, tha the physician-patient relationship should not be disturbed

Dr. Barnum: Mr. Chairman, I have been wondering whether or not we might not perhaps utilize the incom tax report as a basis for determining the eligibility of th client for a treatment on the basis of the indemnity.

President Miller: It is interesting to see the question come up. We have considered all these in committee. Th

*See January Journal, page 67.
†See January Journal, page 38.
**See January Journal, page 60.
††See January Journal, page 35.
***See January Journal, page 65.

come tax was first suggested by the committee as one of e means. It was quickly brought to our attention that ere are many deductions and immunities in the income s, and that it is an extremely complicated area. If one ys, "income" period, then it leaves the whole situation tween the doctor and his individual patient. One patient ll have a family of a dozen children, have a mortgage the house, and he may be earning over the income nit. I don't believe there are any physicians here who will se the privilege of charging that man more than the nedule. That is what we mean, that there is nothing bitrary about this at all. It leaves the physician and the tient to come to their own conclusion.

DR. WELD: Mr. Chairman, I would like to ask if your mmittee is still of the opinion that the ceiling limit should $2,000, and $3,000, as in the report, in view of the rising st of living, the rising wages, and the rising of everything e?

PRESIDENT MILLER: The opinion of the committee on that, could not express. I can tell you what I think personally, d that is that there is a compromise here between the come level which physicians will work under, and the come level which will induce people to buy the contract. rhaps I can make that clear another way. If the income el is too low, it is no inducement for the worker in e factory to buy the contract, nor for the employer to y it for him. If the income level is too high, physicians ll not subject themselves to the restrictions. Now, whether at level which we have suggested, which is the level taken om Rhode Island, is correct or not, I do not know. We e told that a great many people will not be covered by at in industry.

DR. WELD: Mr. Chairman, may I ask Mr. Farrell to give a little of his experience on that particular point, during e short time this program has been in operation in Rhode and.

CHAIRMAN MURDOCK: I would ask unanimous consent of e House of Delegates that Mr. Farrell, the executive secre- y of the Rhode Island State Medical Society, be given e privilege of the floor to discuss this. Is there objection? not, I will present Mr. Farrell of Rhode Island. Mr. Farrell.

MR. FARRELL: I thought I was coming down here to cape a meeting. Do I understand you want me to answer e question before the House?

PRESIDENT MILLER: With reference to the income level.

MR. FARRELL: We went through that question of the in- me level in Rhode Island, and I think we are faced with e same series of questions that are running through your nds. There is the question of dependents, the question of come level. Those will not be easily solved. We have signed ourselves to that. But I can tell you briefly what e thinking is, and the procedure that is now going through th our health insurance committee that is carrying out the ndates of the House of Delegates.

First of all, we understand, at least from the committee's nking, that the term "dependent" doesn't just mean nors. It could mean an aged mother or someone else. on advice of legal counsel we are going to interpret as e definition for a dependent, the income tax statement, e statute, which provides that a member of a family who receives one-half or more of his support from the insured person is considered a dependent. That is used by the income tax department. That is a question of dependents.

Now, as far as income level, that will be debated. We have already run into it as far as the labor people go. Wages are higher now than they may be a year or five years from now. They may stay up where they are. We are going to start with a $2,000 and $3,000 limit, and find out what happens after a year or so. In your plan, just as in ours, there is provision that those income limits can be changed after we have obtained experience.

We feel we are starting from scratch on it, and in all the medical care plans across the country, they have used the $2,000 and $3,000 base without any difficulty. The experience has been very good, as far as checking on the individual.

Now there is one thing that we did refer to legal counsel, and I can tell you the reaction there as to how the doctor is going to find out whether the person is within or outside the outer income limit. I go along with Dr. Miller. I think they are doing it every day, and you will just have to figure the average person; and I still maintain that nine out of ten are on the square, and you won't have the difficulty that is posed generally in all this thinking that somebody is going to try to take advantage. Most of your insurance contracts are going to be sold on a group basis, and that means that the insured person knows that the doctor, the insurance company, or whoever wants to investigate, can soon find out what his wages are, as far as his earned income. So I don't think you are going to find people who are going to take the risk of putting down a false statement when they come to your office.

We feel that we are going to instruct our membership that, if there is any question, they can ask the patient, when he is required to fill out his assignment of pay or indemnity, "What did you estimate as your gross income in filing your income tax?" That is possibly question No. 1. And then question No. 2 would be, "How many dependents have you?" And then, "What is the income of those dependents?" You don't need to know what his income is, or what the dependents are. Those are for him to decide, and he will certainly know that the total amount of what he puts down or will put down is $3,000 or under. That is a responsibility for him to sign.

I ran into a situation yesterday of a surgeon who refused to become a participating physician purely because he didn't want to interrogate his patient on his social status. My only answer to that is that we have drafted a "direction to pay" form which differs a little bit from yours, and we intend to furnish our membership with pads of these forms. It is parellel in a great many ways to the one that you have in front of you, but there are a few changes. On it we have spelled out in detail what the eligible income group is. In our way of thinking, the physician would only have to place that form in front of the patient, if he says he has a contract, and say, "Well, kindly read that over and make sure you are within that eligible income group."

He can also say, "I am not checking on you, but the insurance company can, and can nullify your insurance. It is your responsibility with them more so than with me. I contract for the services, provided you are in the group.

You testify you are." And the patient has to sign the form that he is or is not in the eligible group. That becomes more or less a legal document. It is sent to the insurance company to get your assignment of indemnity, and it is on record. I don't think you will find many people who will walk into any office, whether it is a doctor's or otherwise, and sign a document for a service, that he is getting $3,000, when he is getting $8,000 or $5,000, or whatever the amount happens to be. So we are hopeful in that respect.

The only other thing that I would mention is an item that has come up in connection with that same question 5, the unearned income which isn't mentioned in your report, wasn't mentioned in ours. But we have added on our "direction to pay" form something additional. It may be an unusual case, but it is one of those doors we are always trying to close, I suppose, before we meet the situation. The question has come up that a man may not have $2,000 of earned income in wages. He may have a retirement fund. He may have an annuity. He may have resources that do not show in his earned income, so he has no $2,000 limit. As a point of illustration, a surgeon in our House of Delegates raised the question that he had performed an operative procedure upon a patient who had, to his knowledge, assets of $76,000 that he admitted, but he had no earned income. We have obviated that situation by providing in our definition and adding, "that provided the individual's gross unearned income does not exceed $500 per year at the time of disability." That is for the $2,000 limit. For the $3,000 limit, it is $1,000 unearned income. And we have defined unearned income as any income other than compensation for personal services actually rendered.

I don't know whether that is something that you want to consider, or leave it to your committee. It was left to our committee to take that point into consideration, and we are adding it on the "direction to pay" form.

I have answered the questions that were raised. I have probably taken you further afield than you wanted to go, Dr. Miller. But if there is any question while I am up here, I will be glad to answer it.

President Miller: Does that clear up the question?

Dr. Creadick: I think that brings out the question that was in my mind. It isn't clear from either state report that this insurance, of course, is to benefit people of the lower income group. But as I understand it, it will be sold to everyone, and only benefits specified will apply to those under the $2,000 and $3,000 rate. I wanted to know who makes that inquiry, the insurance company or the physician. I doubt it very much whether the physician is going to make that inquiry in the presence of the acute emergency. I think the question has been brought out.

I don't think it yet has been settled as to whether this insurance will not be sold to anybody over that income bracket, or whether it will be sold, and we will have to establish some mechanism for making this inquiry.

President Miller: I thought that was abundantly clear, that this is an indemnity insurance which can be bought by anyone. In any event, the insurance company pays him dollars. Below certain incomes, he can assign it with the agreement on the part of the physician that he will be charged no extra.

Dr. Creadick: If everybody understands that, I think th is clear.

President Miller: I think perhaps many physicians we misled by the incorrect statement which occurred in the fir announcement in the press.

Dr. Foster: Has mention been made on the cost of this Has mention been made of how much it will be sold for b the insurance company, and will there be much deman for it?

President Miller: We have not inquired into the cos There is a long report—I can show it to you—of sever hundred pages, just issued by the Federal Security Agenc a report on Blue Cross and federal service plans. There an abundance of information here. The costs are, let us sa broadly comparable to the cost of hospitalization. They ar as the physicians say, in that order of magnitude.

Dr. Meyer: Has it ever been considered whether th $2,000 or $3,000 group is class distinction? I understand a insurance company cannot write policies, for example, say ing, "We will only insure Catholics or Protestants or Jew or Negroes." A lay person asked me that question.

President Miller: That is a very good question to ge clear. The insurance company makes no statement as t what is going to happen to this money. They write a cor tract to deliver money, in the event that a certain thin transpires. Who you are or how you live or how muc money you have is not their concern. You have bough something. You will get indemnities in the event that tha happens.

The only contract concerning this income level is be tween the State Society and its own members. That shoul be made very clear. If there is any halter placed around th neck of medicine in this regard, we have hold of the othe end of the rope, nobody else does.

Dr. Watson: I am wondering why, at this particular tim of the highest national income in the history of the Unite States, and probably the highest average working wage along with the high cost of living—in other words, we ar in a great era of prosperity at this moment—I wonder wh our committee thinks it is so necessary at this particula time that this matter be acted upon. I mean, it seems to m that there is a possibility that this action is not necessar at this time.

Dr. Miller: We have been at this nine years. This is no a sudden thing. We were instructed one year ago to d this, and this is the outcome of that instruction. We believ thoroughly in buying an umbrella when it is still sunshiny and the rain is coming tomorrow or the next day. I thin that expresses our feeling.

Chairman Murdock: Are there any other questions?

Dr. Miller: There is one question I would like to answe myself, because it has not been asked. I expected it woul be. It may be in the minds of some of you gentlemen.

That is the question of why we don't write insurance fo medical coverage. There is nothing in this plan that forbid that. We are dealing with a basic minimum requirement in order to get the plan going. Any insurance company that wishes to take the risk of medical coverage will d so. Many of them are already extending coverage for med

il serviees in hospitals, and under some eonditions outse. I would call your attention, however, to this ehange: ey are doing it, so far, in this state, on their own. They e never eonstulted the State Medieal Soeiety about those ntraets. If they do it now, with the commendation of the edical Soeiety, they submit the eontraets to us. In so far that is an improvement of position, I will leave it to you consider.

Chairman Murdock: Any other questions?

Dr. Barnum: Mr. Chairman, you spoke about having an brella before it began to rain. I was wondering if it was ite eorreet that we are one of the eleven states whieh n't have this kind of thing already.

President Miller: It is true we are one of the few states hieh has not already embarked upon sueh a plan.

Chairman Murdock: Other questions?

Dr. Beckwith: Mr. Chairman, I am simply curious as to ether or not the sehedule of fees includes all follow-up ls that may be neeessary in any given case, or is that for hieh you might call the first treatment only?

President Miller: It is eommon with all of these plans t it ineludes the eare attendant upon that operation in hospital. For instanee, in maternity work, the prenatal d postnatal ealls are not included.

Chairman Murdock: Dr. Beekwith, Dr. Barker suggests t this is covered in Sehedule B, on page 3, to answer ur question. Are there other questions?

Dr. Moorad: I have been requested by a urologist in my mmunity to bring up the question of the differenee beeen the minimum rates recommended by the speeialty ard, in eomparison to the figures appearing under this n. The question is, will subseribing to this plan in any y jeopardize a man's standing in his specialty group? n I speeifie enough in my question? In other words, the nimum fee sehedule recommended by the eommittee for ologieal work, for a cireumeision, say, is $10. Under the esent plan we are considering, it is $5. If this particular ologist agrees to follow along, will that in any way influee his position with his national society, as it will be at lf the rate? That will be half the rate recommended by e American Urological Society.

President Miller: I couldn't answer the question. Medl specialty boards, I will point out, have no standing in ganized medicine.

Dr. Watson: What percentage of the population does is eommittee figure falls within the $2,000 and $3,000 nits?

Dr. Miller: The committee has no reliable figures on at. It is not a question of how many are in the population. is how many in employed groups in the population. ildren, of course, won't come into this unless one of the rents is employed. There is no way that I know of figurg the percentages.

Dr. Sullivan: I would like to ask a question. Will this n be asked to reduce fees in general, not only for those at eome under the insurance, but for those who don't? other words, let's say somebody making $5,000 or $6,000 d this insurance, and he was allowed a certain amount on and then the fee for a surgical operation might be double that amount. Wouldn't this tend to make a general revision downward of the surgieal fees, for example, for everyone?

President Miller: I have an idea that in rural eommunities it would have a good deal of effeet. The smaller the community, the more effeet it might have. It eomes down, however, to an agreement between the patient and the physician. If the physician is willing to do a job for a eertain amount of money, this agreement can be arrived at.

Dr. Thoms: Mr. Chairman, one thing that hasn't been brought out here—I am sure we all think about it—in this whole plan, is that if we don't do this for ourselves, it may be done for us. I think that that is one thing we should remember.

Dr. McCrann: Sinee the announeement of this plan first appeared in the newspapers, I, like many other delegates, I am sure, have been anxious to know the reaetion of our fellow members in the state society. I have found a great dearth of knowledge on the part of the other members of the society. In general, I think they are for a plan, but this has been brought forth in sueh a short time that they are unwilling to commit themselves without being given further information as to the inner workings of the plan. I think that aetion, taken at this time, without fully notifying and aequainting every member of the soeiety with the workings of the plan, would be a bit premature.

Dr. Miller: Mr. President, Dr. MeCrann voieed a thought that has been going through my mind in talking with a good many doetors, and I would like to make a motion that this plan be submitted, this report in its entirety, be submitted to the entire membership of the soeiety; seeond, that the eounty medical soeieties forthwith have a speeial meeting for the eonsideration of the report; and that this House of Delegates be called for a special meeting by the eouneil in about two months to eonsider this matter. I would like to make that in the form of a motion.

Chairman Murdock: Is that motion seeonded?

The motion was seeonded.

Chairman Murdock: The motion has been made and seconded. Will you discuss it?

Dr. Watson: I would like to suggest that that is rather a short time for this proposition. It seems to me we are being rushed. There are lots of things about this fee schedule that I don't like, and I can assure you that many others probably don't like some things about it, too. I do general orthopedics, and I can assure you that there are certain fractures that I won't take care of, even if I get paid five dollars for a femur. I don't think I am going to take care of it for six months for that money. However, that is incidental. I think we should be given a little time. We have a sister state in Rhode Island that is embarking on this plan. Perhaps at the end of six months' time, they can give us some factors about this that can help us a great deal more. I am wondering if it shouldn't go through the regular procedure and be referred back to the county to be acted upon, and then, at our next meeting of the House of Delegates, which will be in about six months from now, we perhaps all would be more intelligent about it. I am not amending the motion. That is only discussion.

Chairman Murdock: You are not amending the motion?

Dr. Watson: No, it is only a part of the discussion.

Dr. Danaher: Mr. Chairman, I don't believe it is necessary to send this back to the county. We have had a lot of opportunity to think about this. As far as I can find out, many physicians, until something is breathing down their necks, they just won't think about it. I believe that we have had a committee working on this for nine years. These men have made a very good study about prepaid medical plans. I don't believe that if it goes back to the counties, and we waste two or three more months thinking about it, that we will get as good a plan as the one that is here. To be sure, there are a few things in the plan that probably ought to be changed. The doctor raised the question of orthopedic fees. I think that some further thought should be given, and probably those fees should be revised. I also think that as far as assistant fees, that the plan in Rhode Island is better than ours. But I believe, from discussion here, that this committee will learn something of what we think about this plan, and they will be able to go forward, and I think they should be empowered with the plan, with due respect to the suggestions that are made by the members of this House of Delegates.

Dr. Gildersleeve: Mr. Chairman, we discussed this plan at considerable length at our trustees' meeting of the New London County Medical Association. We were very favorably impressed, of course, but it was the unanimous opinion of the trustees, and the resolution was made, that the delegates should be instructed that this plan be sent back to the various associations for their discussion. We are unanimous and strong, that the county associations be given an opportunity to discuss this plan. Certainly, if this plan is going to go through, it has got to have the wholehearted cooperation of all the members, and I am afraid a lot of the men are going to feel that something is being put over on them unless they have a chance to know about it at a county meeting.

Dr. Schechtman: I think the committee, after working so many years to bring this plan forth, would be the last ones to object to an increase of time to several months later than the two months that have been suggested by our chairman. Therefore, I would like to introduce an amendment to the motion to change the time so that this plan can be printed and be circulated to every member of the society. It can be taken up for due consideration at the April meetings of each county, and the delegates can then be instructed, and can come back here for action at the regular annual meeting in May.

President Miller: The plan is already printed. It can be distributed to the membership within the week. If you know the national situation as I have had occasion to know it, and have sat face to face with some of these senatorial committees, you know that postponing it for another six months just isn't in the cards. That is the way I feel about it. I feel that many men get religion just before they get executed. I think doctors get excited about this just before they think something is going to happen to them. I don't think it is going to take more than a couple of months.

If, in two months, you come back here and say. "We will still want more time on this," fine. But I don't think that we should again have fingers pointed at us, and have people say, "The doctors can't make up their minds. They are dilatory, and all they are doing is postponing." That has been said of us too often. I hope the House will accept th motion.

Dr. Barnum: I am sorry to speak so many times. It do seem to me that we have got to recognize the human fra ties all of us possess. If we have got a thing handed to u as we are going to get in a week or so, if we haven't hea about it before, and we are told that we are going to l asked about it next May, where will it go? It will go the bottom of the pile, and we will never see it again, eve in May. I think the way to get this job done is to stril while the iron is hot, tell these people when they get th publication of this plan, as it is embodied here, that the are going to have a county meeting on this thing right awa soon, that they are going to have ample discussion at th meeting, that the House of Delegates expects to act upo it within a relatively short time. I think the thing to do to strike while the iron is hot, and get it done.

Dr. Pitock: I want to object to the amendment to th proposed motion of Dr. Miller. This society has been did dling around with this matter, in my own personal exper ence, from 1932 or 1933. I can recall a meeting in Greer wich—I think it was in 1935 or 1936—which was brough up with the specific purpose of beating other factors to th draw, so that proposals along the line of prepaid medica prepaid hospital care, prepaid surgical fees, would be brough up by the society, and led by the society. We had a specia meeting down there. We distributed the result, and the wor of many, many months, to the individual members of th county society. At that time it was completely nullified b the fact that the membership didn't even read the proposa

Further delay in matters of this sort will leave the society to be told that old vulgarity which ends, "either—or ge off the pot."

Dr. Burlingame: I would like to endorse what the las speaker has said. Anybody who is at all aware of what i going on realizes two things. A certain amount of time must be given to the members to really read and digest this But still, time is the essence. If we don't act, we are playing into the hands of the enemy. I think the original motion by Dr. Miller serves both purposes. I urge that we delay not one minute beyond the time proposed. I ask the question.

The motion was then offered by the chairman and carried

Dr. Hastings: May I ask one question before the subject is entirely disposed of? Obviously, as we all know, one of the subjects in this proposal which will come up for the sharpest debate within the county societies will be the fee schedule. I mean that is where the needle hurts. What opportunity is there or what system has been set up so that if a county expresses itself as in favor of the plan, in general, but very decidedly in disfavor of one or two of your fees, what can be done about that?

That is the thing that we will have to battle when we get into our counties. I think we should all know about it.

President Miller: As you go back to the counties and talk this over, there is the necessity of coming to certain compromises. If every specialist should get in the fee schedule what he thinks his services are worth, you would have a premium, the level of which would knock your eye out, and you wouldn't sell a single contract. You must realize—

d this is a criticism always hurled at us—that this takes obstetrics and surgery. There must be added to that entgenology and medical care. That all costs money. That adds to the premium. We have to bear in mind that we ll have to produce a contract that can be sold. It has got work. So that people who have, let us say, too exalted eas, will have to make some compromise. I think there are me mistakes in this fee schedule, too. I could tell you a few of them right now. I found a few high, and I think me are too low. But this is a compromise, and we have ken what they have done in Rhode Island because we have t to get some experience. Those are the general thoughts.

Dr. Buckhout: I have one more question to ask, and that in our own group, our own men, going back to our unties, they may not be qualified to take everything that going to come to us on this. I wonder if there is any y of our drawing on the men who do know all about I recognize that Dr. Miller, for instance, is doing a good al on this, and it would be awful to have him visit eight unties and stand their fire. And yet I think we should ve a qualified person to answer everything, when we do ld our meetings

President Miller: The various members of the committee ll be at your service And in so far as my strength and e strength of Dr. Barker lasts, we will come and be at ur service

Dr. Watson: I just want to add one more thing. I have Kiplinger Letter, dated June 14, 1947. I just want to bring fore this group the vastness of this program. I am not ainst the basis of the program. But according to this letter, o-thirds of the families in the United States, presumably, e in the $3,000 or less classification. So it is a pretty all-nbracing proposition that we are facing.

Dr. Harvey: May I comment on that last statement? That the over-all population of the United States, isn't it?

Dr. Watson: Yes.

Dr. Harvey: It doesn't obtain in the State of Connecticut.

Dr. Miller: For your information, the average income in e State of Connecticut and Rhode Island has been neck d neck at the top of the list, $1,465, or thereabouts, each them. That is the average. That means nothing, since t takes in men, women, and children.

Chairman Murdock: I might say, if I had seen Dr. Harvey in the room earlier, he would have been presiding.

Dr. Barstow: One more question on the discussion. Do nderstand that policies written that cover this plan will available to individuals as well as to employed groups? n any individual buy one, in other words?

President Miller: If you read this carefully, you will note e following, "In this connection, we are hopeful that oid progress can be made through incorporating these nefits into the hundreds of existing group insurance plans the state, as well as to the adoption of the program by ny new groups. We are, of course, optimistic that ways d means will be found to market this type of insurance individuals and families on a large scale, but the under-iting and sales problems to be solved are obviously more ficult than in the case of groups of employees."

Dr. Barstow: We have nothing to offer the individuals der this plan?

President Miller: He can buy it now, but it costs him a great deal, because he has to pay an individual commission and the risk is great.

Dr. Barstow: Thank you.

President Miller: Are there any further questions?

Chairman Murdock stepped down, and President Miller resumed the chair.

President Miller: Next is the report of the trustees of the building fund, Dr. Gold.

Dr. Gold read his report.* This was accepted.

Dr. Miller: With your indulgence, I will call at this time on Dr. Harvey, Item No. 14, Program Committee. Dr. Harvey has to leave very shortly.

Dr. Harvey: Mr. President, the Program Committee already has met once, and it meets once again within a week or so. The general program will follow, in a general way, that of last year. We haven't actually gotten to the point of designating the speakers. The secretary, I think, can give you the time and place more precisely than I can at the moment. I would like to say this, however, that the committee would greatly desire that anyone who has any criticism or comments or suggestions to make concerning the program send them to the program committee. Like some of the previous discussion here, the program committee, when it meets with regard to the program, is operating to a considerable extent in a vacuum, and trying to guess what the members want, and any further information that we can get will be of great value to us.

Secretary Barker: The president has suggested that I repeat for you the date of the meeting. It will be held in the Roger Ludlowe High School in Fairfield, just west of Bridgeport, as you know, and it is readily acceptable. It will be held on the 27, 28, and 29 of April. The House of Delegates will meet on the 27th of April, as usual, all day. The scientific sessions will be on the 28th and 29th of April. The annual dinner of the society will be on the evening of the 28th. Those days are Tuesday, Wednesday, and Thursday. They are not the handiest dates for us. We would prefer to meet in May, somewhat later on, but we are limited because of the time we can get to use the public high school. As the president has already pointed out, rather, the chairman of the council, we were just put to it to find a place to have this meeting. The way it looks now, the public high schools are the only places that are suitable for our use.

President Miller: If there are no questions, this committee report will be accepted and placed on file.

Next is the report of the Committee to Study the Organization and Objectives of the Society.

Dr. Bishop read his report.†

President Miller: Thank you, Dr. Bishop. Are there any comments on this report? I know, from personal observation, that a tremendous amount of work has been done by this committee. If there are no comments, it will be accepted and placed on file. Next is the report of the Committee on Cooperation with the Yale School of Medicine, Dr. Murdock.

*See January Journal, page 39.

†See January Journal, page 62.

Dr. Murdock read his report.†

PRESIDENT MILLER: You have heard the report of this committee. There are some suggestions in there that might call for action. Do I hear any motions?

DR. GOLD: I move the report be accepted.

The motion was seconded.

PRESIDENT MILLER: It has been moved and seconded that the report be accepted. Will you comment?

MR. WATSON: What does accepting the report mean?

PRESIDENT MILLER: Accepting the report means adopting the contents thereof, if you so decide.

DR. WELD: Mr. Chairman, I wish the chairman who read the report might repeat his recommendations, so all the members will know what has been going on.

DR. MURDOCK: Your committee recommends that the sum of $10,000 be appropriated over a period of two years for the purpose of organizing post-graduate education for the members. That is the only recommendation we have to offer.

PRESIDENT MILLER: The acceptance of this report will carry with it an authorization of the expenditure of that money.

Any comment?

DR. BARNUM: Mr. President, do I correctly understand that we have a surplus of something like $5,000 in our Clinical Congress Fund? That might perhaps help us to get started on this program. If that is so, I think it would ease the way a little bit. I think that if we are going to appropriate $10,000, that is a little bit less than two dollars apiece for each member of the society. It would look to me like we ought to raise the ante enough to match that, if we are going to vote to spend $10,000. If we are going to take $5,000 out of the Clinical Congress Fund, it looks to me that that is just about two dollars to match it right now. Am I correct on that?

PRESIDENT MILLER: There is money in the Clinical Congress Fund. All of that money belongs to the State Society, and is under the control of the Treasurer, and of the Council, which is the Finance Committee, which, I believe, can be trusted to take the money from the proper places.

DR. BARNUM: Even so, we ought to raise the ante on our assessment, shouldn't we?

DR. LANDRY: I am not a delegate—

PRESIDENT MILLER: I will ask unanimous consent. Is that granted? Those in favor say aye. Contrary? Dr. Landry has the floor.

DR. LANDRY: I want to ask Dr. Murdock if that money will be expended for postgraduate education, or is it to be expended for the running of this diagnostic clinic?

DR. MURDOCK: Oh, no, no. It is purely for postgraduate education, and that is very specific. The medical school will donate the same amount. The diagnostic clinic is an entirely separate thing.

PRESIDENT MILLER: Is there any further discussion?

DR. THOMS: I think we ought to bear in mind that this postgraduate education program that may be planned or developed not only considers postgraduate education from the postdoctorate level, that is, to the members of the so ety, but also considers investigating the resident traini system throughout the state, and helping that in eve way. So that it is a very big program, and certainly is som thing that is going to take the services of a full time dire tor. It is a very broad thing, if it goes into effect.

PRESIDENT MILLER: Is there any further discussion?

DR. SCHECHTMAN: Once again I rise to ask for a delay action, because I feel that an appropriation of this kind quite large, and suffiicent information has not been giv to the House to permit us to intelligently decide as what we are appropriating it for. It is true that the proje has been named, but what that project will consist of, a what it will embrace, and what the extent of it will l we do not know as yet. It seems to me the more order form of business would be proceeding to present the pr ject as it is to be, and then ask the House for an appropri tion at the appropriate time.

PRESIDENT MILLER: Is there any other comment? If not, will put the question.

The motion was then carried.

PRESIDENT MILLER: We will ask Mr. Burch for the Repo of the Committee on Public Relations.*

DR. BURLINGAME: Mr. Burch is preoccupied at the m ment. That is fortunate because it gives me an opportuni to express an opinion about his work. With your consent will read the first part of the report of the committee, whic he has prepared.

Dr. Burlingame read the report.

DR. BURLINGAME: Then he gives a rather detailed repor You have appropriated $5,500 to public relations for th coming year. The progress made by Mr. Burch has bee astonishing. I have had altogether too much experienee i this public relations work, but I have never seen anythin like the activity and the accomplishment of Mr. Burel And I bespeak of you a motion of commendation for M Burch. I ask you to look at some of his handiwork.

PRESIDENT MILLER: You have heard the report of D Burlingame. Are there any comments If not, it will be a cepted and placed on file.

Next is the report of the Committee on Medical Care Veterans, Dr. Canfield.

DR. CANFIELD: I am reporting for Dr. Rentsch, chairma of the committee.

Dr. Canfield read his report.†

DR. CANFIELD: We will have a further report in a fe months.

I am sure you have all seen in the public press th resignation of Dr. Hawley. As far as I know, his successo has not been named. However, the Administrator of th Veterans Administration, Mr. Gray, from Chicago, has bee named. And when he takes office on the first of January he will probably then name his medical successor to D Hawley.

PRESIDENT MILLER: You have heard the report of D Canfield. Have you any questions on it? This is a goo opportunity to ask any questions.

†See January JOURNAL, page 74.

*See January JOURNAL, page 63.
†See January JOURNAL, page 64.

Dr. Murdock: Mr. President, I would like to make this mment, that I think medicine has a friend in court in e new appointee in the Veterans Bureau, Mr. Gray, whose other is an extremely well known surgeon of the Mayo linic, Dr. Howard Gray. I think we can feel that we have friend in Court, in the Veterans Administration.

President Miller: If there are no further comments, this port will be accepted and placed on file.

The Secretary has a report of the Committee on Tumor udy.

Secretary Barker read the report.*

Secretary Barker: Mr. Chairman, I move the adoption this report.

The motion was seconded.

Preident Miller: Any comments? All those in favor say e. Contrary? So ordered.

I will call for the report of the Committee on Workmen's mpensation, Dr. Soltz.

Dr. Soltz read his report.†

President Miller: You have heard the report. What is ur pleasure?

Dr. Thoms: Mr. President, is this a progress report of is committee or a final report?

Dr. Soltz: This is a progress report.

President Miller: There is no action requested?

Dr. Soltz. No action requested.

President Miller: It will be accepted and placed on file, less there is objection. Hearing none, it is so ordered.

You have the report of the Committee on Military History of the Society. Dr. Barker has that.

Secretary Barker: This report is submitted by Dr. Ralph lman, the chairman of the committee on the Military istory of the Society.

Secretary Barker read the report.**

President Miller: This is a report of progress. If there no objection, it will be accepted and placed on file.

There is also the Report of the Advisory Committee to e State Health Department on Psychiatric Clinics.

Secretary Barker: This is a report submitted by Dr. mes C. Fox, the chairman of this Advisory Committee. Dr. Barker read the report.‡

This was accepted as read.

President Miller: Is there any report that you would like make, Dr. Gardner? Dr. Gardner is chairman of the mmittee on Rural Medical Service.

Dr. Gardner: I would like to make a short report for e Committee on Rural Medical Service, just to say that e First Connecticut Conference on Rural Health was ld at the University of Connecticut in July. The attendce was not what we had hoped it would be, but everyone t that it was a good start. We know from experience w that a farmer may get sick at any time of the year, but it is awfully hard to pry him away from the farm during the summer. Therefore, we hope this year to have a smaller regional conference, perhaps in Litchfield County, to which the rural population in that particular area will be invited. And if that group is successful, we hope to continue that throughout the state. I think that the Committee on Rural Medical Service has at least stimulated some thought in the rural communities with regard to the betterment of health in each instance. The questionnaires were reported on fully by Dr. Mooney. They were given out by Mrs. Ruth Clark to her home demonstration group. She told me personally that it brought forth many discussions and many questions as to whether or not medical care was all that it should be in the particular town.

In short, the committee is still at it.

President Miller: Are there any comments? If not, that report will be accepted and placed on file. Has any member something he would wish to bring before the House?

Dr Murdock: Mr. President, I would like to make an unusual motion at this time. It is customary in county societies, when members die, that they be paid proper respect by the county societies. Since the Annual Meeting in April of this House of Delegates, two prominent members of this society have passed on. I think of Dr. D. C. Y. Moore of Hartford, who was, I think, twice elected president of his county society, and who was councilor representing Hartford County until April of this year; and I think of Dr. Ralph E. McDonnell, who has been an officer in the New Haven County Medical Association for a great many years, and, as long as I can remember, has been a member each succeeding year of the House of Delegates.

And I move, Mr. President, that the Secretary be instructed to draft suitable resolutions on the death of these two men, and that these resolutions be incorporated in the minutes of this meeting as a permanent record, and that copies of the resolutions be sent to Mrs. Moore and Mrs. McDonnell.

Dr. Weld: Mr. President, I would like to add to that the name of Dr. Charles C. Gildersleeve, who is one of our past presidents.

Dr. Murdock: Oh, yes, certainly.

The motion was seconded.

President Miller: The motion has been made and seconded that the secretary draft suitable resolutions on the deaths of these three men. Any further comments? Those in favor say aye. Contrary? It is carried.

The following resolutions were prepared by Secretary Barker and are hereby incorporated in the minutes:

RESOLUTION ON THE DEATH OF DR. CHARLES C. GILDERSLEEVE

The House of Delegates of the Connecticut State Medical Society at its Semi-Annual Meeting held in New Haven on December 4, 1947, voted unanimously to instruct the Secretary to prepare a resolution expressing the sorrow of the House of Delegates in the death of Dr. Charles C. Gildersleeve of Norwich, and a statement of the appreciation of the fine service that he had given to Connecticut medicine for many years. Dr. Gildersleeve served as the President of this Society and will be remembered always as the kind of physician that Connecticut seems to produce, good doctors, good citizens, good friends.

*See January Journal, page 72.
†See January Journal, page 73.
**See January Journal, page 73.
‡See January Journal, page 73.

RESOLUTION OF THE DEATH OF DR. D. C. Y. MOORE

The House of Delegates of the Connecticut State Medical Society at its Semi-Annual Meeting held in New Haven on December 4, 1947, voted unanimously to instruct the Secretary to prepare a resolution expressing the sorrow of the House of Delegates in the death of Dr. D. C. Y. Moore, of Manchester, and a statement of the appreciation of the fine service that he had given to Connecticut medicine for many years. Dr. Moore served as a member of the Council from Hartford County and will be remembered always as the kind of physician that Connecticut seems to produce, good doctors, good citizens, good friends.

RESOLUTION ON THE DEATH OF DR. RALPH E. MCDONNELL

The House of Delegates of the Connecticut State Medical Society at its Semi-Annual Meeting held in New Haven on December 4, 1947, voted unanimously to instruct the Secretary to prepare a resolution expressing the sorrow of the House of Delegates in the death of Dr. Ralph E. McDonnell, of New Haven, and a statement of the appreciation of the fine service that he had given to Connecticut medici for many years. Dr. McDonnell was the President of t New Haven County Medical Association at the time his death and was often a member of the House of Del gates. It had been anticipated that as time went on would be elected to higher offices in the Society and perha follow the way of his distinguished father and be its pre dent. Dr. McDonnell will be remembered always as t kind of physician that Connecticut seems to produce, goo doctors, good citizens, good friends.

PRESIDENT MILLER: If there is nothing further, gentleme adjournment is now in order. May I compliment you carrying through a tremendous agenda. I will promise y this evening, for my part, a disquisition on prepaid medic insurance in words of two and three syllables, which hope will be understandable perhaps in greater measu than some of the legal language that has been used in t program itself.

The meeting is adjourned.

CORRESPONDENCE

On Burying One's Head In the Sand

To the Editor:

I was most interested in Dr. Lawrence Kubie's article in the December issue of the CONNECTICUT STATE MEDICAL JOURNAL. Dr. Kubie is always a stimulating speaker and writer.

He is quite correct in emphasizing the importance of the psychiatric disorders as the greatest public health problem of today. Also, he is correct in saying that the problem will not be solved by burying our heads in the sand. However, neither will it be solved by over-statements and over-claiming.

The first course of action, burying our heads in the sand, results in devastating inaction. The second, over-claiming, has equally devastating results, bringing forth a brief flare-up of public interest, inevitably followed by loss of public confidence. This has been demonstrated only too vividly by the intense public interest in psychiatric casualties evidenced during the war, followed now in newspapers and magazines by a deluge of ridicule against psychiatric aspirations and techniques.

The public health problem of mental disease is sufficiently important and impressive, even confined to statements which are factual beyond question. Let us avoid burying our heads in the sand, and let us also avoid the equally unwise tenure of the panic technique. Let us follow, instead, the lines of fact, as is being done so successfully in the fight against heart disease, cancer and tuberculosis.

I enjoyed Dr. Kubie's article, and hope it will b widely read.

C. C. Burlingame, M.D.

From One of Our Exchanges

Library of Mississippi State Board of Health
Jackson, Mississippi

To the Editor:

May we congratulate you for the nice distinctio accorded the CONNECTICUT JOURNAL at the recer Secretaries-Editors Conference. We think it is a excellent Journal also, attractive in format and usefu in content. We are proud of our file of it, which complete except for two issues of the first volum

It is difficult getting around to writing letters c appreciation as often as we would like to. Howeve we do want to tell you again how very much w appreciate your making the CONNECTICUT STAT MEDICAL JOURNAL available to this Library. I do n know for sure whether it is coming to us in e change for the *Mississippi Doctor* or as an outrigh gift but I feel nonetheless indebted to you for it an as I look around at the numerous other local an state society publications made available to us in th same manner, I am inspired by the free interchang of medical thought which pervades the associatio responsible. The enrichment which accrues to med cal and allied professions who draw upon thes resources and the ultimate benefit to mankind every where can hardly be estimated. One of the joys c being a librarian is to be able to produce wante references and in this respect alone your Journal ha been a real contribution. Thank you so much for i

With every good wish for the holiday season and r the new year.

E. Louise Williams, Librarian

Nursing Educators Compliment Us

Yale University School of Nursing

o the Editor:

We have noted with appreciation the editorial lore Nurses" which appears in the current issue the CONNECTICUT STATE MEDICAL JOURNAL.

In the midst of so much unfavorable publicity it gratifying to find the medical profession urging on its members a more understanding awareness some of the problems with which nursing educars are faced, and with which we can cope only in spirit of mutual responsibility.

Elizabeth Bixler, Dean

THE DOCTOR'S OFFICE

S. Farnum Coffin, Jr., M.D., announces the opening of an office for the practice of pediatrics at iddlesex and Hollow Tree Ridge Roads, Darien.

John B. Flynn, M.D., is now associated in the general practice of medicine with J. Alfred Wilson, .D., William C. Carey, M.D., John H. Huss, M.D., ancis Giuffrida, M.D., at 118 Colony Street, eriden.

Luis D. Gonzalez, M.D., announces the opening an office for the general practice of medicine at Osborne Street, Danbury.

Harry Klein, M.D., announces the opening of an fice for the practice of child psychiatry at 235 shop Street, New Haven.

Ralph J. Littwin, M.D., announces the opening his fice for the practice of roentgenology at 19 High reet, Bristol.

Arthur H. Morse, M.D., announces the establishent of his office at 364 Oak Street, New Haven. actice limited to obstetrics and gynecology.

Edward J. Ottenheimer, M.D., announces that mes W. Major, M.D., will be associated with him the practice of general and thoracic surgery comencing January 1, 1948, Windham Community ospital, Willimantic.

John G. Raymer, M.D., announces the reopening his office at 59 McKinley Avenue, Norwich.

A. L. Soresi, M.D., announces the removal of his office to the Wickersham Professional Building, 133 East 58th Street, New York 22, N. Y. Practice limited to treatment of pain and postoperative adhesions.

OBITUARY

Kenneth M. Wheeler, M.D.

1910 - 1947

On December 19, 1947 Dr. Kenneth M. Wheeler, research microbiologist for the State Department of Health since 1938, died of typhoid fever at the Isolation Hospital in Hartford. He had been ill for about one month when death intervened.

Dr. Wheeler was well known to the many doctors in Connecticut whose patients profited from his work on some of the difficult diagnostic problems referred to him; he was almost equally well known throughout the United States for his work on enteric disease and had become familiar to many on the international stage for his work.

Dr. Wheeler, a native of Great Barrington, Massachusetts, the son of the late Frank T. and his wife, Almira Wheeler, was graduated from the Massachusetts State College at Amherst and received his doctorate in philosophy from Brown University in 1937.

His early work was in immunology of human blood groups and in inheritance of blood groups in rabbits; his later work was almost entirely in the field of enteric pathogens, particularly the dysentery organisms. It was in this field that he won international recognition.

He was a member of the Committee on Dysentery of the International Congress of Microbiologists, of the Society of American Bacteriologists, the American Society of Immunologists, and the American Public Health Association.

Dr. Wheeler was instrumental in starting the first virus disease laboratory in Connecticut. During World War II he aided both the Army and the Navy by his work. He was one of the first to recognize the epidemiological and laboratory advantages in the use of phage for typing typhoid organisms.

Alfred L. Burgdorf, M.D.

SPECIAL NOTICES

THE CONNECTICUT VETERANS ASSOCIATION MEDICAL SOCIETY

February 5

Recent Advancement in the Diagnosis of Disease

Benjamin B. White, consulting gastroenterologist, Veterans Hospital, Newington and the Institute of Living. Hartford, Conn., assistant visiting and chief of Gastrointestinal Clinic, Hartford Hospital

February 12

Treatment of Diabetes Mellitus

Dr. Samuel Donner, attending physician at the Cook Memorial and Mt. Sinai Hospitals, chief of Diabetic Clinic, Cook Memorial Hospital and Hartford Dispensary

February 19

Recent Advancements in X-ray Diagnoses

Dr. Morris H. Levine, roentgenologist at the Hartford Veterans Administration Regional Office

February 26

Motion and Sound Picture

Subject: 1. Bronchial Asthma
2. Bronchial Catheterization
3. Bronchopulmonary Lesions

NATIONAL CONFERENCE ON MEDICAL SERVICE

The National Conference on Medical Service will meet in Chicago on Sunday, February 8. Important controversial subjects affecting medical practice, hospitals and nursing will be discussed. Creighton Barker is president of the Conference.

CONGRESS ON MEDICAL EDUCATION AND LICENSURE

Some of the most important problems facing medical schools at this time will be discussed at the 44th annual Congress on Medical Education and Licensure, to be held under the auspices of the Council on Medical Education and Hospitals and the Federation of State Medical Boards at the Palmer House, Chicago, February 9 and 10, 1948.

Papers on the financial support of medical education will provide a highly significant discussion. The addition to the undergraduate curriculum of courses on the clinical effects of nuclear fission and on physical medicine and rehabilitation will be discussed by authorities in these fields. The recent intense interest in the subject of general medicine makes the review of programs for preparing students for general practice of particular significance.

In addition to the formal program of the congress, s eral national groups concerned with medical education, search, hospitals and licensure will hold special meetin These include the Executive Council of the Associati of American Medical Colleges, the Advisory Board Medical Specialties, the National Board of Medical Exa iners, the National Society for Medical Research a others.

HEALTH EDUCATION WORKSHOP

The Health Education Committee of the Connectic Tuberculosis Association together with several other offic and voluntary health agencies is planning to sponsor a heal education workshop for in-service secondary teachers d ing the summer of 1948. The course will be given at Y University under the leadership of Dr. Charles C. Wilsc professor of education and public health. The course w open on June 28 and continue through August 6 with additional two weeks for completion of any reports papers. The workshop will carry 8 points of credit repr senting ¼ year's work and the tuition will be $150.

Scholarships will be available through the joint cooper tion of various health organizations and possibly throu some local boards of education. Applications for scholarshi should be sent to the Chairman, Scholarship Committe Connecticut Tuberculosis Association, 43 Farmingt Avenue, Hartford 5.

FIRST INDUSTRIAL CONFERENCE ON ALCOHOLISM

The first Industrial Conference on Alcoholism will be he in the Morrison Hotel, Chicago, on Monday, March 1 1948. Sponsored by the Chicago Committee on Alcoholis the Conference has been designed to bring to the attentic of industry leaders throughout the country facts pertai ing to the problem of alcoholic employees and to discu ways and means of overcoming the problem.

The Conference has been divided into three parts—mor ing session, luncheon, and afternoon session.

In the morning session the discussion will center arou "The Problem." Alcoholic definitions such as "What an who is an alcoholic" and the physiological and psycholog cal aspects will be covered by one speaker. A second speak will discuss "Alcoholism as a community problem," settin forth the social aspects, relationship of problems of alc holism to family and community life. The role of publ institutions, such as courts, hospitals, welfare agencies, jail etc., will be reviewed briefly. This session will conclud with two speakers covering the subject "Alcoholism i Industry." One will discuss "The problem of alcoholic em ployees" with emphasis on hazards, accidents, loss of worl time, etc. The second speaker will dwell on the all-im portant phase of the subject "The cost to industry."

A special luncheon is planned at which an outstanding ıthority on the subject will be the keynote speaker.

The afternoon session will cover the subject of "What to) about the problem." Four speakers will discuss "What ın be done for the individual alcoholic." Various types of dividual treatment will be covered; the work of the Yale hool of Alcohol Studies, the Keeley Institute treatment, ıd various types of rehabilitation centers will be outıed. The Alcoholics Anonymous program will also be)vered. The final subject "Responsibility for alleviation and evention" will be covered by two speakers. One will talk ı industry's part in the problem; the other on industry ıd the community.

Speakers will be prominent medical authorities who have ecialized in the disease of alcoholism, and outstanding dustry representatives who are conscious of the problem.

Reservations for attending the technical sessions and the ncheon may be made by writing Walter O. Cromwell, ice President, Chicago Committee on Alcoholism, 816 uth Halsted Street, Chicago 7, Illinois.

POSTGRADUATE COURSE IN DISEASES OF THE CHEST

The American College of Chest Physicians, Pennsylvania apter, and the Laennec Society of Philadelphia are sponring a postgraduate course in diseases of the chest to be ld during the week of March 15-20, 1948, at the Warwick otel, Philadelphia, Pennsylvania.

The emphasis in this course will be placed on the newer velopments in all aspects of diagnosis and treatment of seases of the chest.

The course will be limited to 30 physicians. Tuition fee $50 for members, and $90 for non-members.

Further information may be secured at the office of the nerican College of Chest Physicians, 500 North Dearborn reet, Chicago 10, Illinois.

CONFERENCE ON EDUCATION FOR PROFESSIONAL RESPONSIBILITY

The Inter-Professions Conference on Education for Prosional Responsibility will be held at the Inn, Buck Hill lls, Pennsylvania, April 12, 13 and 14. A battery of outnding educators in law, medicine, divinity, business and gineering will swap experiences and conclusions in dealing th three broad questions covering the toughest and most ic problems of professional education. Chairman of the ee sessions are Donald K. David, dean of the Harvard aduate School of Business Administration; Karl T. Compn, president, Massachusetts Institute of Technology; and thur T. Vanderbilt, dean of the Law School, New York iversity, and former president of the American Bar sociation. The conference, which is being sponsored by Carnegie Corporation of New York is limited to 100 ited specialists in education. Medicine will be represented ong the speakers by James H. Means, professor of clinical dicine, Harvard Medical School, and John Romano, prosor of psychiatry, University of Rochester School of Medicine and Dentistry. Eleanor Cockcrill, professor of social work, University of Pittsburgh, will discuss medicine as viewed by a social case worker.

INVITATION TO ALL SURGEONS TO ATTEND INTERNATIONAL SURGICAL ASSEMBLY

The Sixth International Assembly of the International College of Surgeons will be held in Rome, Italy, at the invitation of the Italian Government, during the week of May 16-23, 1948, under the presidency of Professors Raffaele Bastianelli and Raffaele Paolucci of Rome, and Mario Dogliotti of Turin. The secretary of the Assembly is Professor Giuseppe Bendandi of Rome. Attendance is not limited to the membership of the College; all surgeons in good standing in their medical organizations are invited. Scientific meetings, scientific and commercial exhibits, visits to the Universities of Turin and Milan have been arranged, together with tours to other medical centers in Europe. A special exhibit of ancient texts on surgery is being arranged by Professor Davide Giordano of Venice, honorary president, under the active presidency of Professor Adalberto Pazzini, professor of history at the University of Rome. This extraordinary exhibit dealing with ancient surgery will be on display in the Vallicelliana Library in one of the historical buildings of the Vatican. Detailed information may be obtained from Dr. Max Thorek, General Secretary, 850 Irving Park Road, Chicago 13. For travel information, address the All Nations Travel Bureau, 38 S. Dearborn Street, Chicago, the official travel representatives for this Assembly. Those desiring to present scientific papers address Dr. Karl Meyer, Cook County Hospital, Chicago; Dr. Henry W. Meyerding, Mayo Foundation, Rochester, Minesota; or Dr. Herbert Acuff, Acuff Clinic, 514 W. Church Street, Knoxville, Tennessee. Those from Canada should direct their inquiries to Dr. Lyon Appleby, 925 W. Georgia Street, Vancouver, B. C.

FIRST INTERNATIONAL POLIOMYELITIS CONFERENCE

Official delegates from more than 60 foreign governments will be invited to participate in the First International Poliomyelitis Conference at the Waldorf-Astoria Hotel in New York City next July 12 to 17, the National Foundation for Infantile Paralysis, sponsor of the conference, has announced.

The foreign delegates will be asked to present summarizations of the problems of poliomyelitis in their countries at a special session presided over by Thomas Parran, M.D., Washington, D. C., Surgeon General of the United States Public Health Service.

Official host to the delegates will be Basil O'Connor, New York, president of the national foundation. Hart E. Van Riper, M.D., Washington, D. C., the foundation's medical director, has been appointed general chairman of the conference.

The program is being arranged by a seven-member advisory board which includes Irvin Abell, M.D., Louisville, clinical professor of surgery at the University of Louisville; Morris Fishbein, M.D., Chicago, *editor of The Journal*

of the American Medical Association; David Lloyd, PH.D., New York, associate member of the Rockefeller Institute for Medical Research; Kenneth Maxcy, M.D., Baltimore, professor of epidemiology at Johns Hopkins University; Frank Ober, M.D., Boston, professor emeritus of orthopedic surgery at Harvard University, and Thomas Rivers, M.D., New York, director of the Hospital of the Rockefeller Institute for Medical Research.

In addition to reports on poliomyelitis research and treatment by professional authorities and panel discussions on the various subjects, there will be a scientific exhibit section, demonstrations of muscle testing and treatment proeedures, and a film program. Coordinating this phase of the conference will be an advisory committee of Thomas G. Hull, PH.D., Chicago, director of scientific exhibits of the American Medical Assoeiation, and Charles F. Branch, M D., Boston, director of scientific exhibits of the American College of Surgeons.

DIETETIC ASSOCIATION CONVENTION

The 31st annual convention of the American Dietetic Association will be held in Boston from October 18 through October 22. Meetings in connection with the convention will be held in the Hotel Statler, and exhibition space has ben reserved in Mechanics Hall.

THE AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

At the annual meeting of The American Otorhinologic Soeiety for the Advancement of Plastic and Reconstructive Surgery the following officers were eleeted for 1948-9:

President: Jacob Daley, New York, N. Y.; Vice President: Samuel Kelley, New York, N. Y.; Secretary: Norman N. Smith, New Haven. Conn.; Treasurer, Benjamin Shuster, Philadelphia, Pa.; Board of Directors: Bert E. Ellis, Indianapolis, Ind.; Samuel Segal, Jr., Springfield, Mass.; Ben R. Dysart, Pasadena, California; Clarence Rubendall, Omaha, Nebraska; Samuel Salinger, Chicago, Illinois; Ralph H. Riggs, Shreveport, Louisiana.

The next regular meeting of the Society will be held at the County Medical Society Building, Philadelphia, Pa., on Thursday, February 26, at 8:00 P. M. Programs of the meeting may be obtained from the Secretary, Dr. Norman N. Smith, 291 Whitney Avenue, New Haven, Connecticut.

VA HOSPITAL OFFERS NP RESIDENCY

Openings are available in Neuropsychiatric Residency at the Veterans Administration Hospital, Lyons, New Jersey.

The program consists of one, two or three years training with intensive postgraduate teaching in Clinical Neurology and Psychiatry, Psychopathology, Clinical Psychology and related Sciences, in Neuroanatomy, Neurophysiology, Neuropathology and Neuro-roentgenology, also experience in Female and Child Outpatient Psychiatry and Inhospit Training for Female Patients and Feebleminded Childr and Juvenile Delinquents.

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The Residency has been approved by the Council c Medical Education and Hospitals, American Medical Ass ciation and by the American Board of Psychiatry an Neurology.

TWENTIETH ANNIVERSARY YEAR OF HAROFE HAIVRI

The Hebrew Medical Journal

The attention of the medical profession is directed to th appearance of the Fall issue of *Harofe Haivri* (The Hebre Medieal Journal), a semi-annual bilingual publication edite by Moses Einhorn, M.D.

In the medical section, the following subjects are offerec "The Importance of the Rh Factor in Clinical Medicine by Philip Levine, M.D., and "Pharmacology and Toxicolog of Streptomycin" by Ernst Pick, M.D.

The section on Palestine and Health contains the follow ing articles: "The Contribution of Bacteriologists for th Control of Infectious Diseases in Palestine," by L. Olitzk M.D., of the Hebrew University; "The Present Status c Tubereulosis in Palestine" by A. Wolowelsky, M.D., and "Plastic Surgery in Palestine" by Ernst Wodak, M.D.

Under the heading of Historical Medicine Dr. Leo Nemoy of Yale University writes on the great philosophe and physician of the 13th century—Ibn Kammuna. D Yom-Tov Levinsky discusses in his article on Folklor Medicine, the legends surrounding frogs and spiders a healing agents.

The original articles are summarized in English to mak them available to those who are unable to read Hebrew The editorial office of *The Hebrew Medical Journal*, 98 Park Avenue, New York 28, N. Y., will be glad to furnis any further information desired.

OUR NEIGHBORS

Massachusetts

Dr. Guy W. Brugler of Cleveland Heights, Ohio has been named director of the Children's Hospital Boston. Dr. Brugler has been assistant director o University Hospitals in Cleveland since 1939. Dur ing this period he was on leave of absence for two years as lieutenant colonel, U. S. Army.

New Jersey

The Medical Society of New Jersey, by action of s Trustees, adopted a resolution on November 16, 947, calling for: (1) the subsidizing of nurses aining schools under the general direction of Rutgers University; (2) financial assistance from the ate in defraying hospital costs for the medically ndigent; and (3) an expanding program for the are of beneficiaries of the State Department of nstitutions and Agencies. While these proposals ould require the state to raise additional funds, ey will (a) produce more and better hospital and ursing service, (b) help perfect and improve the oluntary hospital system, and (c) relieve self-upporting patients in some measure of an almost nbearable burden, much of which is properly a harge against the community at large.

These proposals were discussed informally with epresentatives of the State Nurse and Hospital ssociations before being acted upon by the rustees. They are strictly in line with a current ffort on the part of the Hospital communities to ay charges of hospitals in amounts more nearly pproaching the actual cost of care for public cases. he officers of the Medical Society of New Jersey el that these proposals need and deserve the support of every member of the Society.

New York

At a dinner celebrating the progress of Associated Hospital Service on November 19, 1947, Bernard M. Baruch outlined a 15 point program for improving medical and hospital services with provisions for government financed protection for needy individuals. Among the steps he specifically advocated were a survey to modernize medical education with greater emphasis on chronic and degenerative diseases, mental hygiene and preventive medicine; fewer specialists and more general practitioners; the reorganization of medical practice with emphasis on group medicine and voluntary health insurance; a new cabinet post for health, education and social security; and the creation of a non political watchdog committee to safeguard progress in medical care for veterans.

New York University College of Medicine in conjunction with the Division of Vocational Rehabilitation of the N. Y. State Department of Education is undertaking a joint survey of about 1,000 persons with heart disease to determine the appropriateness of their jobs. The clinic where this work is being carried on will offer guidance to those in unsuitable vocations to enable them to secure gainful employment.

NEWS
from County Associations

Fairfield

The Nathaniel Witherall Hospital in Greenwich has appointed as resident physician Emil Herrman, a veteran general practitioner in Czechoslovakia before his internment by the Germans at the onset of World War II.

Francis P. Carroll, former president of the Bridgeport Medical Association died in Bridgeport on January 2 following a long illness.

Hartford

Arthur S. Grant, roentgenologist in New Britain for more than 25 years, died suddenly in his office on December 11, 1947. Prior to engaging in private practice in 1930, Dr. Grant was a member of the x-ray department at the New Britain General Hospital.

John R. Lincoln, resident physician at the Hartford Hospital, has been appointed head of the department of anestheisa at the Maine General Hospital, Portland, Maine.

The Newington Board of Selectmen has announced the appointment of two local physicians to town offices. John J. Freeman was appointed as town health officer and Vincent D. O'Neil was appointed police surgeon. Dr. Freeman succeeds Dr. Theodore H. Sills who with his temporary withdrawal from private practice tendered his resignation as town health officer after many years of service. The office of police surgeon is a newly created one, with Dr. O'Neil as the first holder.

The physicians now or previously associated with Hartford Hospital recently exceeded their objective of $150,000 by $10,252 in the hospital's final drive for funds for its new building.

Benjamin L. Salvin of Hartford has been notified that he has been elevated from a fellow to a founder

fellow by the qualification board of the International College of Surgeons.

On January 5, 1948, one hundred seventy-five members of the Hartford Medical Society attended in great force the most gala annual meeting ever held in the memory of those who cast their ballots and ate their steaks.

Dr. C. C. Burlingame and his program committee staged a well planned meeting where business was handled with éclat and reports were succinct and to the point. The business meeting at the Hunt Memorial was interrupted at about 7:30 P. M. for refreshments at the Hartford Club, followed by dinner in the ballroom.

Following oysters on the half-shell to baked Alaska, Hugh Thompson, baritone of the Metropolitan Opera Association, pulled the members out of the chairs repeatedly with the finest male singing ever heard within those walls.

The interrupted business meeting was then continued at which time the following officers were elected: Benedict B. Landry, president; Donald B. Wells, president-elect; Rocco Romaniello, secretary; Benjamin L. Salvin, assistant secretary; David Gaberman, treasurer; Maurice T. Root, assistant treasurer; Edward J. Whalen, librarian; Louis P. Hastings, assistant librarian; Louis F. Middlebrook, assistant librarian.

Dr. Burlingame in his retiring address lauded the work of the state hospitals for the mentally ill and pleaded for greater active support of their work by the medical profession as a whole. Throughout his remarks he pointed out that there was no longer any real difference between psychiatry and general medicine since the distinctions were fast disappearing.

The evening saw a fitting climax in Mr. Thompson's matchless singing of fine programmed numbers and several loudly applauded encores.

On January 8 the Hartford County Medical Association at the Hunt Memorial met to consider the prepaid surgical and obstetrical insurance plan drawn by the State Medical Society.

The County Association voted that it favored in principle this program but was interested in a broader base and for that reason voted to refer it back to the State Society for further study and investigation. There were about 100 members present and the discussion covered many phases of the plan and though great interest was shown there was little heat and much light cast upon the situation.

Litchfield

A motion was passed that the Litchfield County Medical Association approve the adoption by the House of Delegates of the Connecticut State Medical Society the report of the committee on Prepaid Medical Care, and that the committee be authorized in the development of the program to exercise judgment on details within the broad outline of this program with the understanding that due respect will be given by the committee to the following suggestions:

"1. *Schedule A—No. 2.*

" 'The attached Master Schedule of Surgical Indemnities shall serve as a standard for use in connection with this plan. Such Schedule is subject to change by the Society upon reasonable notice, as conditions and experience warrant.'

"Modification as follows:

"The attached Master Schedule of Surgical Indemnities shall serve as a standard for use in connection with this plan where services are rendered up to and including a semi-private level, including such extra services as are deemed necessary by the surgeon: such Schedule is subject to change by the Society as conditions and experience warrant.

"2. *Schedule A—No. 5* be modified in such a manner that individuals or families having an unearned income of over $500 a year will not be included as service patients.

"*Schedule B*—Master Schedule of Surgical Indemnities:

"1. SURGICAL ASSISTANTS: When the nature of an operation is such that the services of an assisting licensed physician (not a resident or intern) are necessary:

"When surgical indemnity is:	Assistant's indemnity is:
$ 50 to $ 99	$10
100 to 150	15

"2. The fee schedule for fractures should be revised similar to the present fee schedule of the United Medical Service of New York.

"3. Some provision should be made for serious intracranial injuries not associated with a fracture of the skull.

"4. Some provision should be made for an indemnity for burns and skin grafts."

An amendment to the motion was passed to the effect that every effort be made to include hospitalized medical care in the plan.



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New Haven

Edward K. Parmelee, formerly medical examiner and a practising physician in Ansonia more than 56 years, died at his home in that city on December 9, 1947. Dr. Parmelee was a charter member of the staff at Griffin Hospital and also served as chief of the medical staff of that institution.

The following nominations for membership in the New Haven Medical Association have been approved by the executive committee: Richard B. Elgosin and James Mazzacane of Hamden, John Riesman of Branford, and Robert R. Berneike, Alphonse Gencarelli, John S. Hathaway, Harry Sigel, Morgan Swirsky, and Fred Zaff, all of New Haven.

William Grillo, University of Rochester Medical School 1938, has been elected to membership in the Waterbury Medical Association.

John N. Russell of Meriden has been appointed for the seventh consecutive year as chairman of the March of Dimes campaign in that city.

The New Haven City Medical Association has not completed its Literary Report for the year 1948. The next meeting of the New Haven City Medical Society will have as its guest speaker Professor Harry Most, professor of tropical medicine at New York University and his subject will be the Diagnosis and Treatment of Colonic and Extra-Colonic Amebiasis.

The Waterbury Medical Society held its annual meeting January 8. C. E. Dwyer gave a paper on prepaid medical care and this was followed by a lively discussion by members of the Society. J. H. Foster was elected president for the coming year.

The Waterbury Hospital has reorganized its staff as suggested by the American College of Surgeons. E. H. Kirschbaum was elected chief of staff.

The Ladies Auxiliary of the Waterbury Medical Society gave a Christmas dance which was well attended and greatly enjoyed. They likewise purchased dishes and kitchen equipment which they have offered to the society for use at any time.

New London

C. Tyson Hewes has returned to his practi following an appendectomy in December.

Clarence Thompson recently underwent operation, and is recovering very well.

The Lawrence and Memorial Hospitals ha started their redecorating program. The first flo ceilings have all been soundproofed, and the em gency room has been redecorated.

Recent additions to the staff of the Lawren Hospital are as follows: to the Medical Sta Milton W. Fabricant and Joseph M. Ganey, Jr.; the Surgical Staff: A. Duncan MacDougall.

Charles Krinsky of New London has recen been appointed an Associate of the American C lege of Physicians.

Windham

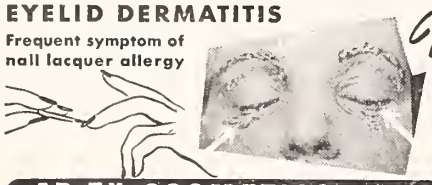
Edward J. Ottenheimer of Willimantic has turned to his surgical practice in that city after absence of four months. He will have as his assist James W. Major of New Haven.

The activity in our census department contin unabated. In fact, it seems reasonable that t county has never witnessed the many and rap changes that have occurred since the end of the w There are several new faces arriving on the sce and some of the earlier ones are disappearing:

E. Arthur Barry, Jr., has started practice this p month in Plainfield.

Fred Clark Collier has begun practice in Sou Coventry which is in Tolland County geograp ically, but which is really in Windham rather th Tolland County area, since the majority of patients needing hospitalization go to the Windha Hospital in Willimantic. Dr. Collier plans on ope ing a second office in Willimantic, at 781 Ma Street, as soon as the necessary renovations a completed. He plans to maintain offices in bo places.

Joseph E. Nowrey has joined the staff at t

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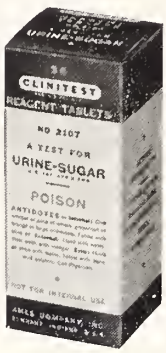
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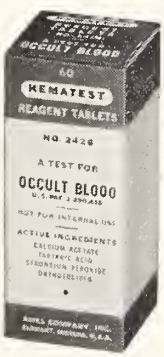
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ELKHART, INDIANA

Mansfield Training School and has applied f membership in the Windham County Associati This means a further augmentation of the resider staff at the Mansfield Hospital.

Still another newcomer is James W. Major w has just finished a residency at the New Hav Hospital. Dr. Major is to be the new associate E. J. Ottenheimer who has returned to active pra tice after a number of months absence. Dr. Maj takes the place vacated by Dr. John Raymer.

Dr. Raymer has returned to Norwich where had practiced for many years, and had just reopen an office when he had the ill fortune to be involv in an automobile accident which has resulted serious injuries.

News from Yale University School of Medicine

Studies made during the past year in the Ya Nutrition Laboratory by Dr. Krehl, assistant pr fessor of nutrition, have revealed a new yardsti for scientific measurement of the role of vitami in nutrition. Dr. Krehl has shown by his resear that vitamin needs must be related to other bodi requirements for fat, carbohydrates, and protein.

The Yale research demonstrated for the first tir that vitamin A deficiency has an extremely clo relationship to vitamin C; that the need for vitam A is related specifically to the level of fat a protein in a diet as such; and that the need f nicotinic acid decreased as the protein level of t diet was raised, providing that the protein add contained trypotophane, one of the amino acids.

Associated with Dr. Krehl in this research wo were Jean Mayer and Dr. Alberto Carvalho, Rock feller Fellows from France and Brazil, respectivel

Emerick Friedman, former clinical director Norwich State Hospital, and Riley H. Guthrie, t present superintendent at the same institution, ha been appointed assistant clinical professors of ps chiatry and mental hygiene at Yale. They will associated with the School of Medicine on a pa time basis. William B. Terhune of New Canaan h been appointed lecturer in psychiatry and ment hygiene at Yale with the rank of associate professo

NEW BOOKS IN REVIEW

EASES OF THE NOSE, THROAT AND EAR. (inth Edition.) *By William Lincoln Ballenger*, M.D., .C.S. Late Professor, School of Medicine, University of nois, Chicago, and *Howard Charles Ballenger*, M.D., .C.S., Associate Professor and Acting Chairman of the partment of Otolaryngology, Northwestern University hool of Medicine, Chicago; Surgeon, Department of olaryngology, Evanston Hospital, Evanston, Illinois. sisted by *John Jacob Ballenger*, B.S., M.D., Research Fel- v in Otolaryngology, Northwestern University School Medicine, Chicago. *Philadelphia: Lea & Febiger.* 1947. 3 pages with 597 illustrations and 16 plates in color. 2.50.

Reviewed by EDWARD J. WHALEN

ere is a text book on Diseases of the Nose, Throat and under the authorship of Ballenger, a name of good te in American Otolaryngology for the past fifty years. , the ninth edition, is a well balanced book brought o date by a few revisions and several additions to the last ne. The section on rhinoplasty is a helpful addition se of the recent lively interest shown by specialists is once neglected field. The chapter on broncho- agology has been contributed by Drs. Tucker and on and will be especially valuable to the graduate stu- s. The subject of otosclerosis is brought up to date by tion on the fenestration operation for the treatment inical otosclerosis.

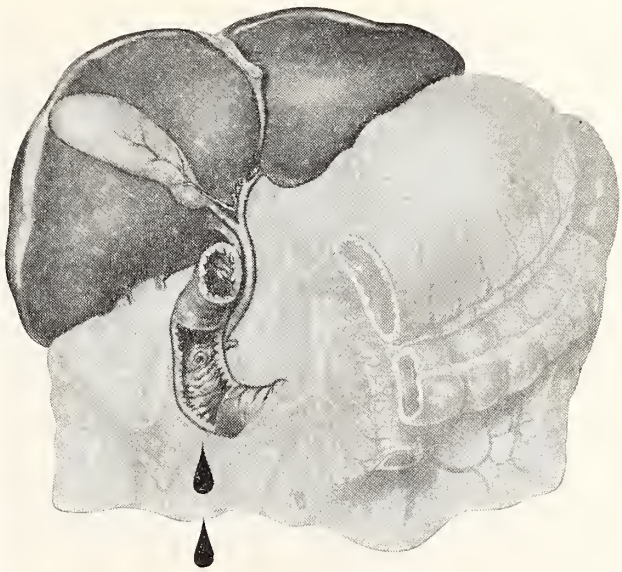
comparison of the first edition issued in 1908 with the nt volume is interesting because of the few advances have been made in our knowledge of disease conditions ting these structures. Antibiotics are now used to treat lle ear infections and have replaced the use of the leech, dvised in the first edition. The 1908 volume described njection of a 4 per cent solution of cocaine as a local hetic for tonsillectomy. Our inclination to smile at treatment is restrained when we remember that we have d but little to our store of knowledge on such subjects sal allergy, otosclerosis and vertigo.

llanger has compiled a good text book that will be used reference volume by specialists as well as a guide for uate students. Future text books will contain more mate- on the physiology of the nose, the respiratory function the physiology of equilibrium.

FORD'S TEXTBOOK OF OPHTHALMOLOGY. ourth Edition.) *By Francis H. Adler*, M.D., Professor Ophthalmology, University of Pennsylvania Medical hool. *Philadelphia and London: W. B. Saunders Com- ny.* 1947. 512 pp. with 310 illustrations. $6.

Reviewed by HENRY L. BIRGE

. Gifford's *Text Book of Ophthalmology* has long ful- a real need on the part of medical men; its small size comprehensive coverage of the subject of ophthalmology rendered it irreplaceable to students, both in medical ols and in private practice; no more reliable quick refer



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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ELKHART, INDIANA

ence to an eye problem can be desired, even by ophthalmologists of experience. The first, second, and third editions by Dr. Gifford will remain a tribute to his concise, well balanced writing. Simplicity and adequate coverage of the problem, without the detail to be found in the larger works, was his aim and accomplishment.

Dr. Adler has enlarged the volume by only 42 pages and has made many changes such as the substitution of the metric system for recording visual acuity: i. e., 6/6 instead of 20/20. Some of the concise clarity with which Dr. Gifford described syndromes, for instance, acute glaucoma, has given way to a style more formalized and complicated and possibly less easy for the new student to grasp and retain.

Dr. Adler's presentation of the essential facts will more than fill all the requirements of any student. The added explanations, the outlines and the diagrams of the pathways in the brain that concern the various ocular and neurologic syndromes are an addition that will please those whose interests lie in the field of neurology. Many omissions such as the neat and simple operations for which Dr. Gifford was noted, or descriptions of aniseikonic lenses will not be noted by the student.

Dr. Adler has enriched his chapters with more profuse illustrations, many new, and also some of the best of the photographs that appear in other classics in ophthalmology and neurology. He has incorporated in the text all the newer concepts of ophthalmopathy, so that even the experienced ophthalmologist will find it worthwhile to study this new edition. His expositions of physio-ophthalmology enrich many chapters with details most clinicians will wish to reread. Especially deserving attention is the latest classification of the retinopathies of hypertension and allied diseases, including toxemias of pregnancy. The surgical ophthalmology has been collected in a chapter entitled "Orientation on Surgical Operations" and has been broadened to include some of the drawings from the surgical text book of Wiener and Alvis. The last chapter deals with ocular therapeutics and has been brought to recent date.

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Some things you should know about the common cold

No. 209 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



MOST PEOPLE in the United States and Canada have two or more colds a year, each lasting about two weeks and causing a considerable amount of stuffy discomfort.

The danger of the common cold lies mainly in the other infections that may follow after it. For a cold lessens your resistance, and is likely to pave the way for other, more serious, respiratory ailments.

Sinusitus, ear infections, bronchitis, and the various forms of pneumonia are frequently ushered in by a cold. Pneumonia, particularly, is likely to attack a person who is overtired, or run-down because of a severe cold.

True, many of these respiratory diseases are not as dangerous as they used to be. (Modern infection-fighting drugs—such as penicillin and the sulpha drugs—offer highly effective treatment for many cases.)

But, of course, it is always better to *prevent* a serious illness whenever possible.

If you have a cold, it's just good sense to stay away from people, to avoid spreading the infection; and to get plenty of rest—in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness.

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever.

SEE YOUR DOCTOR. Never try the foolhardy experiment of dosing yourself. Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

Let your doctor diagnose your ailments. Let him decide what treatment is best for your particular case. Then follow his instructions to the letter. His advice is the only advice you should take on any question that concerns your health.

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CHARTER AND BY-LAWS — CONNECTICUT STATE MEDICAL SOCIETY

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suit of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismission and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all moneys and other property belonging to the corporation in such manner as it may deem advisable to promote the objects and interests of the society and in general to make such by-laws and regulations for the due government of the society, not repugnant to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of the Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society, (2) delegates to be elected annually as hereinafter provided, by the several county medical associations in this State which heretofore have been and are affiliated with the Connecticut State Medical Society and (3) the members of the Council of the Society.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held upon such day in each year as The House of Delegates shall, from time to time, prescribe. Notice of such annual meeting date shall be sent to every affiliated county medical association at least sixty days before each annual meeting date so prescribed.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation in each year, every affiliated county association shall elect a delegate or delegates to represent it in "The House of Delegates" of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in "The House of Delegates," one councilor from each affiliated county medical association. The councilors holding office at the time of the pa of this act shall serve out the terms of office for w they were elected. At their annual meeting to be hel 1931, the affiliated county medical associations for counties of Hartford, New London, Windham, and Mi sex shall each elect one councilor who shall serve for years, and at their annual meeting in 1932 the affili county medical associations for New Haven, Fairfield, Li field and Tolland counties shall each elect one counc who shall serve for two years. Thereafter each county groups as above mentioned, shall, biennially, elect a c cilor to fill said office for a term of two years. Any vac in said office may be filled by the county associatio the county in which the vacancy occurs, by election to the unexpired portion of the term.

Section 7. The secretary of each affiliated county me association in this state, shall, within ten days following meeting of such association at which new members elected, file with the secretary of the society a list of members of such association who are at the time in g and regular standing and thereupon all such persons s become members of The Connecticut State Medical Soc without further action.

BY-LAWS

ARTICLE I

Name

Section 1. Name

Par. 1. The name of this organization shall be The C necticut State Medical Society.

ARTICLE II

Purposes

Section 1. Purposes

Par. 1. The purpose of this Society shall be to fede and bring into one organization the medical profession the State of Connecticut; to unite with similar societies other states to form the American Medical Association; extend medical knowledge and advance medical scienee elevate the standard of medical education, and to pron friendly intercourse among physicians, to enlighten direct public opinion so that the profession shall bec increasingly useful to the public in the prevention and c of disease and in prolonging and adding comfort to life.

Par. 2. The Society is not organized, and shall never maintained and conducted for the pecuniary profit of members, officers, or employees but shall be, and remain strictly scientific and educational corporation, and no m ber, officer or employee of the Society shall at any t receive or be entitled to receive any pecuniary profit fr the operation of the Society except a reasonable compen tion for services actually rendered.

ARTICLE III

Ethics

Section 1. Ethics

Par. 1. The Principles of Medical Ethics of the Ameri Medical Association shall govern the conduct of members their relations to each other and to the public.

ARTICLE IV

Component Associations

Section 1 Component Associations

Par. 1. The county medical associations in the following counties shall be the component associations of The Connecticut State Medical Society: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

ARTICLE V

Membership

Section 1. Membership

Par. 1. The Society shall consist of members, student members, associate members and honorary members.

Section 2. Members

Par. 1. All members in good standing in the component associations shall be members of this Society. Physicians whose names are on the official roster of membership of a component association shall be considered in good standing.

Section 3. Student Members

Par. 1. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 1 of the Cumulative Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Conecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of attending their education and not primarily for remuneration, may become Student Members of the Society.

Par. 2. Such membership shall be obtained by applying to the Council of the Society on a form provided for that purpose and election by vote of a majority of the Council.

Par. 3. Student Members shall enjoy all of the rights and privileges of membership in the Society except that they will not be eligible to vote or hold office, and Student Members shall pay no dues.

Par. 4. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he will be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

Section 4. Associate Members

Par. 1. Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut. may be elected as Associate Members in this Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership which will be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the rights and privileges of the Society except that they may not vote or hold elective office; they may be appointed to serve upon committees and present papers before the Society or any of its sections.

Section 5. Honorary Members

Par. 1. Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article X, Section 3, Paragraph 4. They shall be accorded the privilege of participating in scientific work.

ARTICLE VI

Officers

Section 1. Officers

Par. 1. The officers of this Society shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, an Executive Secretary, a Treasurer, the Editor-in-Chief of the Journal, the elected Delegates to the American Medical Association, and eight Councillors.

Par. 2. The officers, except the President and the Councillors, shall be nominated by the Council and elected annually by ballot of the House of Delegates.

Par. 3. The President-Elect shall be elected annually. He shall serve as President-Elect until the annual session of the Society next ensuing after his election and shall become President upon his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor.

Par. 4. A Councillor who shall serve for two years shall be elected at the annual meeting of each of the county associations in Hartford, New London, Windham and Middlesex counties in the odd years.

Par. 5. A Councillor who shall serve for two years shall be elected at the annual meeting of each of the county associations in New Haven, Fairfield, Litchfield and Tolland counties in the even years.

Par. 6. Any vacancy in the office of Councillor shall be filled by the county association in which the vacancy occurs.

Section 2 Duties of Officers

Par. 1. The President shall preside at meetings of the Society and at meetings of the House of Delegates, shall appoint all committees not otherwise provided for, shall visit the various medical associations throughout the state and shall present an annual address before the Society at a time to be arranged by the Program Committee.

Par. 2. The duties of the President-Elect shall be to aid and assist the President.

Par. 3. The Vice-President shall assist the President in the discharge of his duties, preside at meetings in the absence of the President, or on his request. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the unexpired term by the First Vice-President and he will be succeeded by the Second Vice-President.

Par. 4. The Executive Secretary shall attend the meetings of the House of Delegates, shall verify the eligibility and record the presence of members of the House of Delegates and keep minutes of its proceedings. He shall serve as secretary of the Council and keep a record of its proceedings. He shall provide for the registration of members and

delegates at the annual sessions; he shall, with the cooperation of the secretaries of the component associations, keep a card index roster of all the legal practitioners of medicine in the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall cooperate with the officials of the county associations in the extension of the usefulness of the Society. He shall conduct official correspondence of the Society, notify members of meetings, officers of their election and committees of their appointment and duties. He shall make payment of necessary expenditures from funds allocated by the Treasurer and shall employ such assistance as may be approved by the Council. He may, upon request, supply each component association with the necessary blanks for application for membership and with blanks for making their annual reports. In cooperation with a Program Committee he shall publish and distribute all official programs.

Par. 5. The Treasurer shtall receive all funds due the Society and shall receive bequests and donations on behalf of the Society. He shall remit periodically to the Executive Secretary and to the Editor of the JOURNAL prorated portions of the funds allocated to these officers for the operation of their offices. All other payments by him shall be subject to a written order of the Chairman of the Council, or, in his absence, the President of the Society. The Treasurer shall give bond in a sum and manner of bonding prescribed by the Council. He shall make a report to the House of Delegates at the annual session.

Par. 6. The Editor-in-Chief of the JOURNAL, in addition to the recognized duties of such an office, shall make payment of necessary expenditures from funds allocated to the JOURNAL by the Treasurer. His report of expenditures shall be included in the report of the Treasurer to the House of Delegates at its annual meeting.

ARTICLE VII

MEETINGS

Section 1. Annual Meetings

Par. 1. The Society shall hold an Annual Session during which there shall be held Scientific Meetings which shall be open to all registered members and guests.

Par. 2. The time and place for holding each annual session shall be fixed by the Council.

Section 2. Special Meetings

Par. 1. Special meetings of the Society or House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Section 3. Recommendations

Par. 1. Recommendations made by any Scientific Session or Section Meeting may be submitted to the House of Delegates.

ARTICLE VIII

HOUSE OF DELEGATES

Section 1. House of Delegates

Par. 1. The House of Delegates shall be the legislative and business body of the Society and shall be empowered to carry out the purposes of the Society. It shall consist the delegates elected by the component county associati and the members of the Council.

Par. 2. Each component association shall be entitled send to the House of Delegates each year one delegate every thirty-five members or any additional part of t number. A component county association with less t thirty-five members shall be entitled to one elected mem of the House of Delegates.

Section 2. Duties

Par. 1. The House of Delegates shall elect Delegates a Alternate Delegates from the Society to the House Delegates of the American Medical Association in acco ance with the constitution and by-laws of that body. Th Delegates and Alternates shall take office on the first January following their election and shall serve terms two years.

Par. 2. The House of Delegates shall have authority appoint committees for special purposes from among t members of the Society. Such committees shall make wr ten report through the Council to the House of Delegat and members of these committees may attend meetings the House of Delegates and participate in the discussion reports submitted by them.

Par. 3. The House of Delegates may provide for division of the scientific work of the Society into appr priate sections.

Par. 4. No memorial or resolution shall be issued in t name of the Society without first having been approved l the House of Delegates.

Section 3. Meetings

Par. 1. The Annual Meeting of the House of Delegat shall be called by the Council and shall be held during t week of the Annual Session of the Society. The order business shall be arranged as a separate section of the pr gram by the Council. The President of the Society sh preside at all meetings or designate one of the Vice-Pre dents to preside in his absence.

Par. 2. A Semi-Annual Meeting shall be held when r quired at a place and date to be set by the Council.

Par. 3. Special Meetings of the House of Delegates m be called by the President or by the Council and shall l called by the President on petition of ten members of t House of Delegates or fifty members of the Society.

Par. 4. Twenty-five delegates shall constitute a quoru

ARTICLE IX

THE COUNCIL

Section 1. Membership

Par. 1. The Council shall consist of one Councillor fro each County and the President, the President-Elect, t Executive Secretary, the Treasurer, the Editor-in-Chief the JOURNAL and the Delegates to the American Medic Association. Seven members of the Council shall constitu a quorum for the transaction of business.

Section 2. Meetings

Par. 1. The Council shall meet at least once in tw months throughout the year, except during the months

ly, August and September, and at sueh other times as may be called by the Chairman of the Council or upon tition of three members of the Counеil. It shall have its nual Meeting for the purpose of organizing and the elec- n of a chairman at its first meeting following the Annual eeting of the House of Delegates.

Section 3. Duties

Par. 1. The Counеil shall have the power to act for the ouse of Delegates between meetings of that body and shall port sueh action to the House of Delegates at its next eeting.

Par. 2. The Council shall be the Nominating Committee the Soeiety and it shall report as sueh to the first session the Annual Meeting of the House of Delegates. After e report has been made an opportunity shall be given for ner nominations to be made.

Par. 3. The Counеil shall be the Board of Censors of the eiety. It shall eonsider all questions involving the rights d standing of members, in relation to other members, to e eomponent associations, or to this Soeiety. All questions an ethieal nature brought before the House of Delegates the General Meeting shall be referred to the Counеil thout discussion. It shall hear and deeide all questions diseipline affeeting the eonduct of members or compon- t assoeiations on whieh an appeal is taken, and its decision all sueh matters shall be final.

Par. 4. The Counеil shall serve as a Board of Review for ses of elaimed malpraetiee referred to it by the Committee Medieal Ethics and Deportment of any component unty Assoeiation.

Par. 5. The Counеil shall be the Finance Committee of e Soeiety and shall superintend and direet all finaneial nsactions of the Soeiety and shall prepare and submit nually to the House of Delegates a budget for the oper- on of the Society.

Par. 6. The Council shall make an Annual Report to the ouse of Delegates.

ARTICLE X

Committees

Section 1. Standing Committees

Par. 1. The Standing Committees of the Soeiety shall be follows:

A Committee on Arrangements.
A Committee on the Clinical Congress.
An Editorial Board of the Journal.
A Committee on Honorary Members and Degrees.
A Committee on Hospitals.
A Committee on Industrial Health.
A Committee on Medical Education and Licensure.
A Program Committee.
A Committee on Public Health.
A Committee on Public Policy and Legislation.
A Committee on Public Relations.
A Committee on Tumor Study.

Par. 2. Unless otherwise specified in these by-laws, nom- ations for these committees and their chairmen shall be de by the Counеil and presented to the Annual Meeting the House of Delegates.

Par. 3. All standing eommittees exeept the Committee on Arrangements shall make annual written reports to the Counеil before the first of April of eaeh year for transmittal with reeommendations to the Annual Meeting of the House of Delegates.

Section 2. Special Committees

Par. 1. Special committees may be appointed by the Counеil or eleeted by the House of Delegates as may from time to time be required. Committees appointed by the Counеil shall make written reports to the Counеil as directed by it. Committees eleeted by the House of Delegates shall make written reports to the Counеil in the same manner as provided for standing eommittees.

Section 3. Duties of Committees

Par. 1. The Committee on Arrangements shall be appointed by the eomponent assoeiation with which the Annual Session of the Soeiety is to be held. It shall provide suitable aeeommodations for the meeting places of the Soeiety, and of the Speeial Sections, and of the House of Delegates, and of their respeetive eommittees. Its chairman shall report an outline of the arrangements to the Exeeutive Seeretary for publieation in the program.

Par. 2. The Council shall nominate to the House of Delegates each year a Committee on the Clinieal Congress, and its Chairman, a Seereatry and a Treasurer. The function of the eommittee shall be the arrangement and direction of the annual Clinieal Congress of the Society and such other aetivities in postgraduate instruetion as may from time to time appear desirable to the eommittee. The Chairman, the Secretary and the Treasurer shall be the trustees, of the funds of the Clinieal Congress, and this Committee, through its Treasurer, shall receive ineome from registration fees of the Congress and other sourees of ineome ineident to the administration of the Congress, and pay therefrom all necessary expenses. This fund shall be audited by the Society's auditors and a report of the transactions of the fund for the fiscal year shall be rendered by the Treasurer of the Clinical Congress to the House of Delegates each year at its Annual Meeting. The Treasurer of the Clinical Congress shall give bond in a sum and manner of bonding prescribed by the Counеil. He shall remit to the general fund of the Society such part of the funds of the Clinical Congress as the Counеil from time to time may direct.

Par. 3. The Council shall nominate to the House of Delegates each year an Editorial Board for the Journal consisting of five members, and nominate the Chairman of the Board who shall serve as Editor-in-Chief of the Journal. The Editor-in-Chief shall be a member of the Council. In addition to the Board so nominated, the President of the Society shall serve as an ex-officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the Connecticut State Medical Journal and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

Par. 4. The Committee on Honorary Members and Degrees shall consist of the three latest Past Presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the

Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

Par. 5. The Council shall nominate annually to the House of Delegates a Committee on Hospitals to consist of not less than six members, and shall nominate the Chairman thereof. This Committee shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

Par. 6. The Council shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into health in industry with the purpose of making information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

Par. 7. At each annual meeting the Council shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

Par. 8. The Program Committee shall consist of three members, one member of which shall be nominated annually by the Council for election by the House of Delegates for a term of three years. The Chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange the scientific program for the meetings of the Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months prece the date of the meeting.

Par. 9. The Council shall nominate to the House Delegates annually one member from each compo county association and such additional members as it determine not to exceed fifteen to be the Committee Public Health and nominate the Chairman thereof. Committee on Public Health shall be the representativ the Society in all matters pertaining to public health, san tion, the prevention of contagious diseases, maternal infant welfare. It shall confer from time to time with Connecticut State Health Department and other legal pu health authorities in a manner mutually agreeable, an shall inform the Society concerning matters of pu health and, as occasion arises, recommend for the Socie consideration desirable legal enactments to promote pu health within the State.

Par. 10. The Council shall nominate to the House Delegates annually a Committee on Public Policy and Le lation not to exceed fifteen members and nominate Chairman thereof. The Committee shall include one re sentative from each of the eight component county asso tions of the Society and the Delegates from this Soe to the Amercian Medical Association. The Executive Se tary of the Society shall be a member of this Committee serve as its executive officer. The function of this Commi shall be to review and advise the members of the Soe concerning proposed state and national legislation pertair to the public health, welfare and the practice of medic It shall, as occasion arises, draft and have introdueed i the General Assembly of this State appropriate legislat for improving medical care and the public health wit the State, advise the Society's legislative agent concern the opinion of the Society on pending legislation and su vise and direct the Soeiety's program in the legislative fi

Par. 11. The Council shall nominate to the House Delegates annually a Committee on Public Relations to e sist of eight members and nominate the Chairman ther The funetion of this Committee shall be to inquire into pass upon such phases of public information as deal w the care of the sick and the practice of medicine, and s endeavor to keep the people of Connecticut aceurat and reliably informed concerning matters of public inte in the field of medicine. The Committee shall use its eff to encourage cordial relations and understanding with public press and radio, and cooperate with other committ of the Society in a program of public relations.

Par. 12. The Council shall nominate to the House Delegates annually a Committee on Tumor Study of not than fifteen members and nominate the Chairman ther The funetion of this Committee shall be a continuing st of the problem of malignant disease within the state, inform the members of the Society concerning developme in this field, to encourage and increase accuracy in recognition and treatment of malignant tumors, to cooper with the Connecticut State Department of Health and ot public and private agencies in the establishment and ma tenance of diagnostic tumor clinics for service to indig persons within the state, and as occasion arises make rec mendations to the Society concerning legislation in field.

ARTICLE XI

Funds and Expenses

Section 1. Funds

Par. 1. Funds for the operation of the Society shall be ised by an equal annual per capita assessment from each ember of a component county association, except:

Par. 2. Members who are elected to the county associa- ons at the semi-annual meetings will be assessed one half the annual dues for the year of their election.

Par. 3. Members who have been in good standing in e Society for 40 consecutive years or who have attained e age of 68 and have been members of the Society for years immediately preceding shall be exempt from further ayment of dues upon written request addressed to the reasurer of the Society by the Secretary of the County ssociation in which the physician seeking exemption is a ember and shall continue as active members of the Society joying all rights and privileges.

Par. 4. The dues of any member may be remitted by te of the Council on recommendation of a County ouncillor.

Par. 5. All funds of the Society shall be deposited omptly upon receipt in a state or national bank located the State of Connecticut.

Par. 6. The fiscal year of the Society shall commence on nuary 1 and terminate on December 31 of each year.

Section 2. Budget

Par. 1. The annual budget of the Society shall be pre- red by the Council, as the Finance Committee of the ciety, and be presented to the House of Delegates for proval. Based upon that budget the Council shall recom- end to the House of Delegates the amount of per capita sessment for the ensuing fiscal year. All requests and reso- tions appropriating funds of the Society shall be referred the Council for recommendation to the House of Dele- tes and all such requests and recommendations must be proved by the House of Delegates before funds may be pended.

Section 3. Fidelity Bonds

Par. 1. The Council shall prescribe and provide at the pense of the Society proper fidelity bonds for officers of e Society and other persons responsible for the receipt, stody and disbursement of funds belonging to the Society.

ARTICLE XII

Referendum

Section 1. Referendum

Par. 1. A General Meeting of the Society may, by a vo-thirds vote of the members present, order a general ferendum on any question pending before the House of elegates, and when so ordered the House of Delegates shall bmit such questions to the members of the Society who ay vote by mail or in person, and, if the members voting all comprise a majority of all the members of the Society, majority of such vote shall determine the question and binding on the House of Delegates.

Par. 2. The House of Delegates may, by a two-thirds te of its members present, submit any question before it a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII

Component County Associations

Section 1. Component County Associations

Par. 1. The County Medical Associations in Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham Counties now in operation and in affiliation with The Connecticut State Medical Society shall be the component county associations of this Society.

Section 2. Function

Par. 1. The function of the component medical associations shall be to bring together into one organization the physicians of each county and these associations shall be united for the purpose of organizing the medical profession in the State of Connecticut as provided in Article II, Section 1 of these By-Laws.

Section 3. Eligibility for Membership

Par. 1. All registered physicians licensed under Article 2747 of the General Statutes of the State of Connecticut, 1930, as amended, who have resided and practiced under that license in the State of Connecticut for one year shall be eligible to apply for membership except that student members transferring to active membership as provided in Atricle V, Section 3, Paragraph 4, shall not be required to reside in Connecticut one year before becoming eligible.

Section 4. Application for Membership

Par. 1. A physician who desires to become a member of a county medical association shall obtain from the Secretary of that association an application form which, when completed, shall be returned to the Secretary. A physician living near a county line may hold membership in that county most convenient for him on permission of the association in whose jurisdiction he resides.

Section 5. Transfer of Membership

Par. 1. A member of a component association of the Society who removes his residence to another county within this state and who wishes to transfer his membership to the county association in the county of his new residence may do so upon the presentation of a certificate signed by the Secretary of the county association of which he is a member. This certificate shall state that he is a member in good standing in the association of the county where he previously resided and that his financial obligations to that association for the current year have been paid. The certificate shall be accompanied by a regular application for membership. The association in the county of his new residence shall add him to the rolls of that association without formality and without charging any dues for the remainder of the year of his transfer.

Par. 2. A member of a state medical society in another state, that is a component of the American Medical Association, wishing to transfer his membership to a component county association of this Society shall present to the Secretary of the component association of this Society in which he is seeking membership a certificate from the Secretary of the county or state medical society of his previous residence. This certificate shall state that he is a member in

good standing in that county or state medical association. This certificate and a properly completed application for membership shall be forwarded to the Board of Censors or Credential Committee of the component association in this State in which he is seeking membership and that Board of Censors or Committee on Credentials may recommend his election at the next meeting of the component association without regard to the residence requirement prescribed in Section 3 of this Article.

Section 6. Membership Roster

Par. 1. The Secretary of each component association shall keep an individual record of the members of that association, and this record shall include the full name, address, college degrees with year, medical schools attended with school and year of graduation, hospital affiliations, type of special practice, if any, and date of registration in this state. Notations shall also be made concerning transfer and termination of membership.

Section 7. Discipline

Par. 1. Any member of a component county association who is aggrieved by disciplinary action of the county association of which he is a member shall have the privilege of appealing to the Council of the Society which shall review the charges made against the disciplined member and the findings therein and render a decision concerning the disciplinary action taken; this decision shall be final.

Section 8. Termination of Membership

Par. 1. When membership in a component county association terminates for any cause, membership in the Connecticut State Medical Society shall be terminated automatically as of the same date.

Section 9. Delegates to the House of Delegates of the Society

Par. 1. Each component county association shall be represented in the House of Delegates of the Society on the basis of one delegate for each thirty-five members and any additional part of that number. The component association with less than thirty-five members shall be entitled to one elected delegate.

Par. 2. On or about the 15th of March of each year the Executive Secretary of the Society shall inform the Secretary of each of the component associations of the number of members in good standing in each component association on the 31st of December just preceding, and compute therefrom the number of delegates to which each county association is entitled for the ensuing year.

Par. 3. At least twenty days prior to the Annual Meeting of the House of Delegates the Secretary of each component association shall inform the Executive Secretary of the Society of the names and addresses of the officially elected and qualified delegates from each county association.

Par. 4. In case of the inability of a regularly elected delegate to attend meetings of the House of Delegates, the President or the Secretary of the county association in which the vacancy occurs shall appoint an alternate delegate, with full power to represent that county association during the interim, or until the successor of such regularly elected delegate is elected. Upon the appointment of such alternate delegate, the Secretary of the county association in which the appointment is made shall inform the Executive Secretary of the State Society of the appointment at once before the alternate delegate may be seated in the House of Delegates.

Section 10. Dues

Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to members immediately following January 1st of each year and the component county associations shall forward monies so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In this event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed with the county association before the 15th of January each year.

Section 11. By-Laws

Par. 1. The component county associations shall have the power to adopt only such By-Laws as are not in conflict with the By-Laws of The Connecticut State Medical Society. In the event of an existing or apparent conflict the By-Laws of the Society shall take precedence over those of a component county association.

ARTICLE XIV

Amendments

Section 1. Amendments

Par. 1. The By-Laws of the Society may be amended by a majority vote of the total number of the members of the House of Delegates.

Par. 2. Proposed amendments to the By-Laws shall be submitted first to the Council and published, with the Council's recommendation, in the Connecticut State Medical Journal at least one month prior to the date of the meeting of the House of Delegates at which action thereon is to be taken. Copies of the proposed amendments shall also be forwarded to each member of the House of Delegates with the notices of the meeting at which the amendments are to be acted upon.

ARTICLE XV

Parliamentary Procedure

Section 1. Rules of Order

Par. 1. In all matters of parliamentary procedure the Society shall be governed by Roberts Rules of Order.

Section 2. Enablement Clause

Par. 1. The adoption of these By-Laws rescinds and revokes all previous By-Laws of the Society and supersedes their operation.

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PROBLEMS IN THORACIC SURGERY AS SEEN IN A GENERAL HOSPITAL

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It is the intent of this paper to present four of the more common conditions encountered in the field of chest surgery, conditions which are seen on occasion by all doctors in the smaller communities as well as in the cities. Surgery in the chest has advanced only as rapidly as the allied specialties of anesthesia, physiology and bacteriology, because without the anesthetist, without the anti-bacterial agents and without application of fundamental physiology, surgery in the chest would be impossible. The necessity for cooperation in the handling of these serious illnesses which gravitate to a large hospital became evident to us several years ago. A few doctors interested in chest diseases informally held weekly conferences. These conferences grew in popularity and in usefulness and led to the formation of a chest group. This group now has a wide representation from the many specialties which converge to work together in the management of medical and surgical diseases of the chest. The group is represented by the specialties of general medicine, cardiology, anesthesia, x-ray, nose and throat, pathology, and surgery. The cases and problems of this presentation have all been seen within the past year by the chest group and the recommendations for therapy have been outlined as a result of the combined discussions of these doctors.

The first subject for discussion is spontaneous pneumothorax. Spontaneous pneumothorax is a condition which arises suddenly, often without previous warning in an otherwise healthy individual who experiences a tightening sensation in the chest and difficulty in breathing. The diagnosis is easily established if it is considered. The outstanding findings on physical examination are limited excursion of the chest on the involved side, hyper-resonance, and diminished ausculatory signs. There is sometimes shifting of the mediastinal contents and in extreme cases where tension is present there may be marked intercostal retraction in the efforts of the patient to breathe. An x-ray of the chest makes the diagnosis certain. Pneumothorax may occur as a result of trauma in which the lung or the pleura is injured. Occasionally it can result following the injudicious use of a suction bottle for aspiration of the chest with the inflation of the pleural space with air from the bottle which has been pumped up instead of evacuated. On two occasions recently we have seen bilateral pneumothorax occur in children who have been desperately ill with tracheal obstruction which required tracheotomy to relieve the respiratory obstruction. The treatment of a pneumothorax depends on the degree of tension in the pleural space. When breathing is difficult and tension is suspected prompt removal of the air by aspiration of the pleural space with a needle and syringe should be done as a closed procedure. A monometer to determine the intra-thoracic pressure is not necessary. One can always promptly remove all the air which has accumulated in the chest cavity with safety. In mild cases no specific therapy is needed.

To illustrate the steps in the treatment of pneumothorax let us turn to a very young patient who has had this disease. The patient was a premature female infant born by cesarean section during the seventh month of pregnancy. In the second week of life the child developed a mild staphylococcus

Presented at the Litchfield County Medical Association, Winsted

respiratory infection and right spontaneous pneumothorax. The child was initially treated by aspiration with slight improvement but with recurrence of the symptoms. When aspiration failed, permanent decompression was attempted by the use of a short 20 gauge needle connected with a tube which was placed under a water seal. Relief was not obtained and it was necessary to insert through a trocar a small number eight rubber catheter and attach it to a negative pressure of 4 cm. of water. This method of handling tension pneumothorax is a well recognized one and should be resorted to in the adult or the child without delay when conservative management of repeated aspirations does not promptly control the pneumothorax. In rare cases it has been necessary to perform an exploratory thoracotomy to close the communication in the lung or to carry out a lobectomy. We have not found it necessary so far to resort to either of these radical procedures in any of our patients. In summary then, let it be said that pneumothorax which may be spontaneous, or which may be traumatic but which gives rise to tension should be promptly handled by the withdrawal of air first by aspiration and then if necessary and without undue delay by constant measured suction through a small catheter introduced through a small trocar. Aspiration of the right chest for pneumothorax can be done without hesitation. Aspiration of the left chest for pneumothorax must always be done with the mental reservation that a diaphragmatic hernia through the left diaphragm can give rise to a markedly dilated stomach in the chest which must be differentiated from a spontaneous pneumothorax. The correct management of this disease requires little specialized apparatus. It is often an emergency for which prompt relief is demanded.

The second frequent condition which we still see in spite of the anti-biotics is empyema. We have observed that in many instances empyema has developed in cases in which the pneumonia was treated late or inadequately. The use of sulphanilamides and penicillin has tremendously reduced the incidence of empyema and has in certain cases altered its treatment. Nevertheless, the same old fundamental principles in the management of empyema still exist and they are, in brief, adequate drainage of uncontrolled pus and the maintenance of normal respiratory physiology in accomplishing the drainage. Recently success has ben achieved in the treatment of empyema by aspiration and the introduction of penicillin into the empyema cavity in doses of 50,000 to 100,000 units. This method ha given many satisfactory results in empyema cause by the pneumococcus and in which there has bee no loculation or pocketing. We have used it severa times during the past year with success and als with failure. To illustrate a successful case refer ence is made to a fourteen months old child wh entered the hospital with a pneumococcus pneu monia which had been treated by penicillin but wh subsequently developed empyema. The empyem was handled by multiple aspirations and began t show improvement following the first aspiration an the introduction of penicillin in doses of 25,00 units. After several aspirations with penicillin in stillation the child recovered and left the hospita well and afebrile but with some residual pleura thickening. We have had three adults this year ir whom this method has proved satisfactory. Wher aspiration with penicillin instillation fails then oper drainage should be done. This situation is illustrated by the case of a fifty-four year old negro waite who entered the hospital because of a "severe cold" and blood tinged sputum which began nine days before admission. On admission a full blown left sided empyema with pneumococcus four plus and staphylococcus two plus was present. Repeated aspirations with the instillation of penicillin for a period of two weeks produced clearing of the pus to an almost serous fluid which was sterile. Loculation however occurred and progress ceased, so an open thoracotomy was done which provided good drainage and the patient made an uneventful and satisfactory recovery and has returned to his former job.

Our thinking in the management of empyema leads us to the conclusion that empyema if caused by the pneumococcus should be first treated by aspiration and the instillation of penicillin. If after a fair but not too long clinical trial the empyema is not adequately handled, an open thoracotomy with resection of a three-inch section of rib which will bring dependent drainage, in other words which is at the bottom of the cavity, should be done. Open thoracotomy, of course, should be carried out only after the pus has become thick and the pleural surfaces of the lung have become fixed so that shifting of the mediastinum will not take place.

The next problem which has been an important one with us and which needs consideration involves the parenchyma of the lung and is lung abscess. Lung abscess is a disease which can develop in the face of pneumonitis or pneumonia. It is seen occa-

cally as a late complication of pulmonary infarct. characteristically encountered as a complication owing tonsillectomy or tooth extraction. There o question but that poor mouth hygiene is an portant contributing factor in the development lung abscess. Lung abscess may also follow the alation or aspiration of material by unconscious ple whether from head injury or drunkenness. s well known that the most prominent symptom lung abscess is the raising of large amounts of remely foul smelling sputum. The management lung abscess has been open for many years to ch discussion. There are some who advocate the y early drainage of the abscess. It has been our erience even before the use of penicillin that h postural drainage and bed rest many cases of g abscess have spontaneously healed. It is now t feeling that a patient with a lung abscess should given a fair trial of medical treatment consisting bed rest, postural drainage aided by the broncoope if possible, and penicillin before surgical ervention is considered. Surgery, however, should t be postponed until the abscess has become ronic, thick-walled, multiloculated and difficult drain. If evidence of improvement is not noted the end of two weeks, surgical intervention cerly should be done, or even sooner if overwhelmg infection and spread are present. Operation is o indicated when and if steady improvement ases. It has been our practice when possible to do single-stage drainage of a lung abscess. When the eura is not sufficiently adherent to make this a safe ocedure, a two-stage operation is done in order to low pleural adhesions to take place so that the lung scess can be drained without contaminating the eural space. Occasionally in a chronic lung abscess in one with many pockets, a resection of the lobe the lung involved may be the method of choice. o illustrate these three methods of treatment refernce is made to three cases. The first patient is a man forty-five who allowed himself to enjoy the easures of extreme overindulgence in alcoholic everages with the result that about two weeks ter his bout he developed a cough with foul smellg sputum. It should be also mentioned that his al hygiene was extremely bad. He was admitted the hospital and x-ray examination showed a vity in the right upper lobe. He was treated with ed rest, postural drainage and penicillin and at the d of ten days improvement had begun. He was scharged from the hospital without operation and llow-up x-ray taken three months later showed no residual disease. The next case is a man of forty-seven who entered the hospital with a one week story of right sided chest pain, chills and fever. He had raised dark brown sputum in moderate amounts. On admission to the hospital his initial x-ray showed a pulmonary abscess in the right upper lobe with subsiding pneumonitis. The sputum culture showed hemolytic streptococcus two plus, pneumococcus one plus. He was placed on penicillin and postural drainage. Bronchoscopy was done but was not effective in establishing adequate drainage. On the fifteenth hospital day, inasmuch as improvement had not occurred, operation was advised and a first stage drainage of the abscess carried out. Ten days later the drainage was completed and the abscess cavity entered and packed. He did well and was discharged from the hospital. His follow-up x-ray shows no residual cavity but some pleural thickening to be still present. The third patient with lung abscess first entered the hospital in June 1946 with a lung abscess of the right upper lobe and was treated with bed rest, postural drainage and penicillin with marked improvement of the abscess. He was discharged from the hospital in July at which time his symptoms had improved and his x-ray findings had almost but not quite disappeared. He returned to work and shortly thereafter his cough reappeared and he re-entered the hospital in October with x-ray findings very similar to those seen in June. In view of the long duration of this disease and the inconvenient location for drainage, it was decided that the best method of handling it would be by upper lobe lobectomy. This was done and a rather firm-walled abscess cavity in the upper lobe was found. He made a very satisfactory convalescence and has now returned to work entirely free from symptoms. The postoperative x-ray shows satisfactory expansion of the lower lobe to fill the space created by upper lobectomy.

In summary then, putrid lung abscess is a disease which arises in the face of parenchymatical pulmonary disease such as pneumonia, pneumonitis or infarct and from the aspiration of material, following tooth extractions, tonsillectomy or unconsciousness. It is first a medical problem and should be treated by complete bed rest, postural drainage possibly aided by bronchoscopy, and liberal doses of penicillin. In the event that improvement is not present at the end of a two week period, surgical intervention should be undertaken before chronicity or multi-loculation has developed. The choice of operation is governed by the circumstances in each

case. When clearing takes place with medical management a prolonged period of rest and inactivity is essential to assure complete healing of the abscess so that a recurrence will not take place.

The most urgent and most distressing pulmonary disease which has taken the forefront in recent years is carcinoma of the lung. During the past eleven years in our state 1,426 people have had primary pulmonary carcinoma. This is 3.5 per cent of all carcinoma in the state. In the Hartford Hospital in the past eleven years there have been 166 cases seen.

With the war over, the advances in anesthesia, and the return of several doctors in our hospital

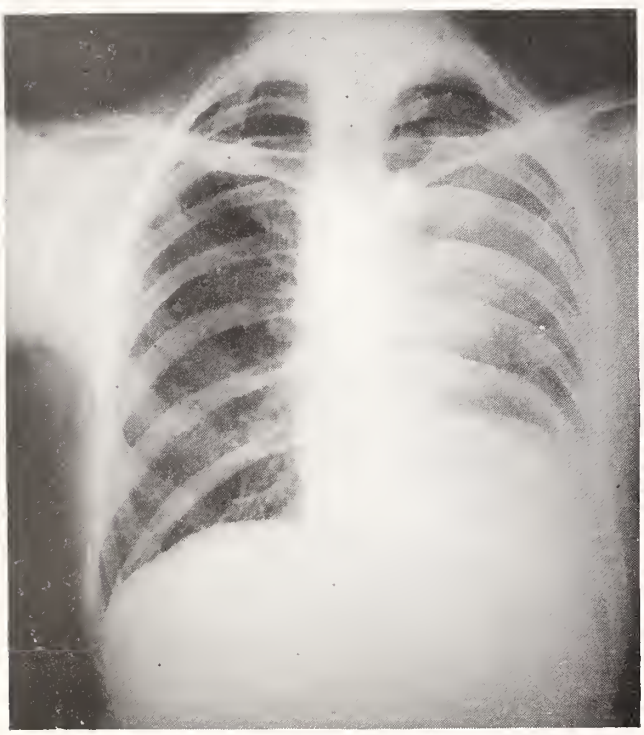


FIGURE I

X-ray of chest showing residual pneumonitis and atelectasis of the right upper lobe

interested in this disease, progress certainly has been made. However a great deal is left to be done. Carcinoma of the lung is increasing in incidence. The diagnosis is more frequently made than it used to be. Nevertheless, early diagnosis is still an extremely difficult thing to accomplish because the disease may produce few symptoms. Even a small tumor may metastasize early. In certain cases a fairly advanced tumor can hide behind the heart and go unrecognized in the x-ray. Carcinoma of the lung clinically demonstrates itself in several ways. Cough and recurrent bouts of mild respiratory infection in a man of middle life should make one suspiciou carcinoma of the lung. Repeated episodes of s hemoptysis may be present in about one-third of cases and should give rise to suspicion. The pat may first notice a wheeze which has never pr ously been present and which goes unexplai Any respiratory infection which does not prom clear up should be incriminated. X-ray findings atelectasis, of irregular areas of increased density an otherwise normal lung field should lead radiologist to suspect carcinoma. Bronchosco examination can sometimes establish the diagn through a biopsy or through taking of a Papa colaou stain, but negative returns of these diagno



FIGURE II

A lateral x-ray which shows clearly the fissure between the upper and lower lobes and marked atelectasis of the upper lobe which has drawn it forward

procedures should not be considered conclusi evidence against carcinoma of the lung. It is n firmly established that pneumonectomy can be do with reasonable safety. The patient is still able enjoy a comfortable though more leisurely existen than that to which he has been previously accu tomed. During the past year in the Hartford Ho pital there have been nineteen patients with prima tumors of the lung. Dr. Welles Standish and I ha operated upon eight of these pateints with tumo

the lung. In six of these, total pneumonectomy as been done. In two, the disease was so far advanced that resection was utterly impossible. Two patients died following operation. One of these was previously known hypertensive with a previous coronary thrombosis and it was recognized beforehand that a grave risk was being taken by operating.



FIGURE III

Gross specimen of the left lung showing tumor in the main stem bronchus to the upper lobe with secondary bronchiectasis of the upper lobe

It was also realized that if nothing was done, the future of the patient was doomed. The patient died of cardiac failure and irregularity one week after operation. The other patient was a known previous asthmatic and during the postoperative course developed typical asthma in the remaining lung which it was impossible to cope with by any of the known treatments of asthma. He was a man of sixty-five and was unable to withstand the combined load of his asthma and such a major operation. The other four patients did well and left the hospital between the fourteenth and twenty-first postoperative days and are still alive and well. Strangely enough in these four patients three different types of tumors are represented.

The first patient is a woman of forty-three who several months before admission to the hospital noted the onset of dyspnea, chiefly on exertion. Four weeks before admission she developed constant pain in the right upper anterior chest. There was never any cough or hemoptysis. X-ray examination showed marked atelectasis of the right lung chiefly of the upper lobe. Bronchoscopy was done and was positive for tumor. Exploratory thoracotomy was carried out and a right total pneumonectomy was done. The tumor was found to be an adeno-carcinoma. The patient made an uneventful convalescence and left the hospital three weeks after operation. She is now able to do her housework. Her own doctor stated recently that his chief problem with her is to prevent her from gaining too much weight.

The second patient is a woman of fifty-five who

four years before admission noted that when she developed a cold, a persistent cough followed and on several occasions small amounts of blood appeared in the sputum. Three months before admission she had an hemoptysis which appeared without

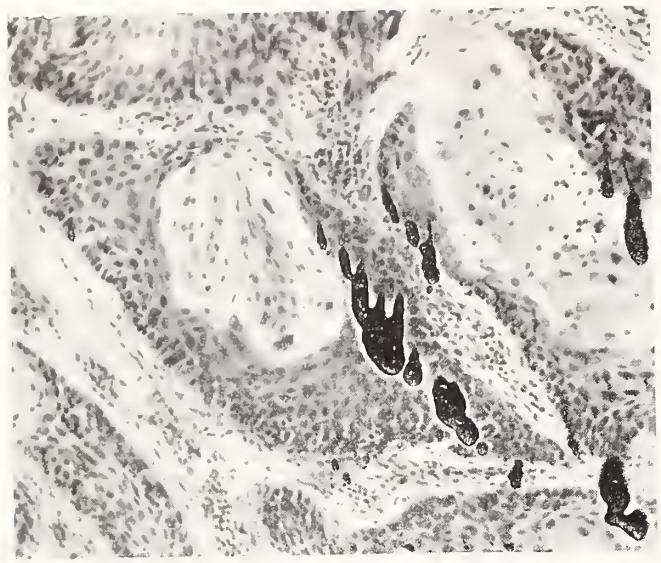


FIGURE IV
Microscopic section of the tumor which was reported squamous cell carcinoma, grade II

warning in her mouth. At this time she consulted her doctor who advised an x-ray of her chest. This showed changes in the right lower lung field suggestive of a tumor. She was admitted to the hospital. Bronchoscopy was done and the biopsy returned negative for tumor. Lipiodal studies showed obstruction of the right middle and lower lobe bronchi. Exploratory thoracotomy was done and a tumor in the upper portion of the right lower lobe was found and pneumonectomy was carried out. The pathological report was returned "adenoma of the bronchus." The patient made a very satisfactory recovery and was discharged from the hospital on the nineteenth postoperative day. This patient is now able to carry out her own housework. Except for some dyspnea on exertion she leads a very comfortable existence.

The third patient, a sixty-six year old man, entered the hospital because of an acute respiratory and pulmonary infection of two weeks duration. For the previous six months, however, he had noticed some shortness of breath on exertion. On admission he had a fever of 102 which responded to penicillin. Repeated x-ray examinations, however, showed that the process in the left chest fai clear and that there was atelectasis of the left lobe. (Figure I and Figure II.) Bronchoscop done and a biopsy was taken from the mouth left upper lobe bronchus and was returned squa cell carminoma, grade II. Exploratory thoracc was done and the entire left lung was removed gross specimen and the microscopic finding shown in Figure III and Figure IV. The p made an uneventful recovery and was disch from the hospital on the seventeenth postope day. He has since returned to his full time jo janitor in a school.

The next patient is a man of fifty-three wh tered the hospital because of cough, wheezin production of small amounts of blood-t sputum of about five months duration. He sulted his physician who referred him to the T culosis Detection Center in Hartford where were taken which led to his admission to the ford Hospital. Initial x-ray examination sh findings suggestive of carcinoma in the apex left lower lobe. Bronchoscopy was done bu biopsy was returned "chronic inflammatory ti Exploratory thoracotomy was done and a tum the upper portion of the left lower lobe was and the entire left lung was removed. The p logical report was returned "epidermoid carci of bronchus." The patient made a smooth p erative convalescence and was discharged fro hospital on the fourteenth postoperative day.

In conclusion let it be said that carcinoma lung is certainly becoming more prevalent year. It is our duty as doctors to bear this d strongly in mind with the hope that early diag can be accomplished through efforts to educat people in our communities to secure medical a early enough so that treatment can be effecti is also our job as doctors to maintain a sharp out and to advise and carry out the necessary nostic measures in order to establish this diag and finally, once the diagnosis has ben establ to do the procedures which are necessary to about a reasonable chance of cure even thou involves such radical surgery as removal o whole lung. Let us hope that the tremendous e which are now being directed against cance disclose a more fundamental knowledge o disease so that perhaps some time it can be trolled without such heroic measures.

PROCEDURES FOR REDUCING MATERNAL MORTALITY

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During the past decade a marked improvement has occurred in the maternal death rate. No other country has experienced such a sharp reduction as has been noted in the United States. It was not until 1933 that accurate records of maternal mortality were available. Since 1943, which was the first year of statistics covering ten years, we have seen the rate drop 63.9 per cent, and the decline has continued each year thereafter. Further improvement can occur in the northern part of the United States, but we cannot reach an enviable position until the southeastern section of our country has improved, since deaths among the negroes are twice as high as among the whites.

Connecticut has one of the highest per capita incomes in America. It rates first in health sanitation standards. These factors contribute to some extent

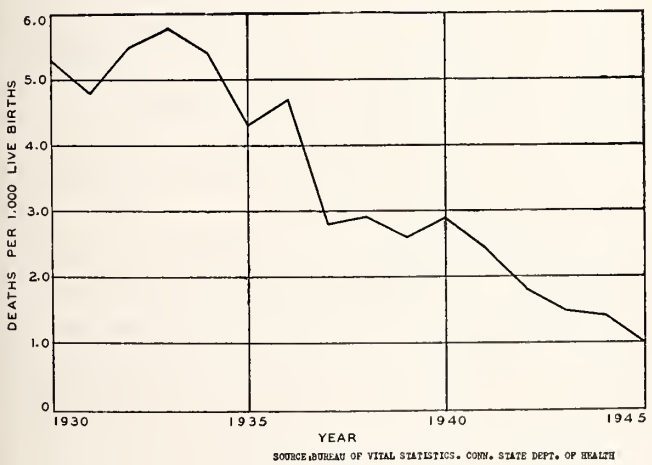


Chart 1

Maternal death rates: Connecticut, 1930-1945

to the lowest maternal mortality rate in the United States which, in 1945, reached a point of 1.0 per 1,000 live births. This is a compact state with good roads, well equipped hospitals easily accessible to even the smallest communuity, and an excellent State Health Department that cooperates at all times with physicians in the State. The type of medical practice by our physicians is well above the average. The decline in maternal mortality in Connecticut from 1900 until 1935 was not impressive. Slight fluctuations occurred, but there was little reduction during this period. However, since 1935 the number of deaths has been impressively and consistently lower each year. The reason for this decline has been a general improvement in the type of medical care, a more concerted effort to educate the people on proper prenatal care, the more liberal use of blood and plasma, and the more extensive use of sulphonamides and penicillin.

During this period the Connecticut State Medical Society, in conjunction with the State Department of Health, has carried on a study of all maternal deaths. Although we pride ourselves in having the lowest maternal mortality rate in the country, we should not be satisfied with our achievements. The rate can be reduced even further. The logical procedure, therefore, is to take an inventory of our deaths over a period of years analyzing each case separately to determine where improvements can be effected.

A sub-committee of the Public Health Committee of the State Society has carefully analyzed each maternal death, and a personal interview with the physician credited with the death has been made. The following presentation includes 191,747 pregnancies in Connecticut from 1940-1945 inclusive, with 321 puerperal deaths.

The maternal death rates throughout the country are classified as infection, hemorrhage, toxemia, and other causes. Infection, in this series, still rates highest as the cause of maternal mortality, but the reduction in deaths from this cause is more rapid than from the others. This is accounted for by the improvement in aseptic technique, but more especially by the introduction of the sulpha drugs and

Presented at the Section on Obstetrics and Gynecology, One Hundred and Fifty-fifth Annual Meeting, Connecticut State Medical Society, Hamden, April 30, 1947

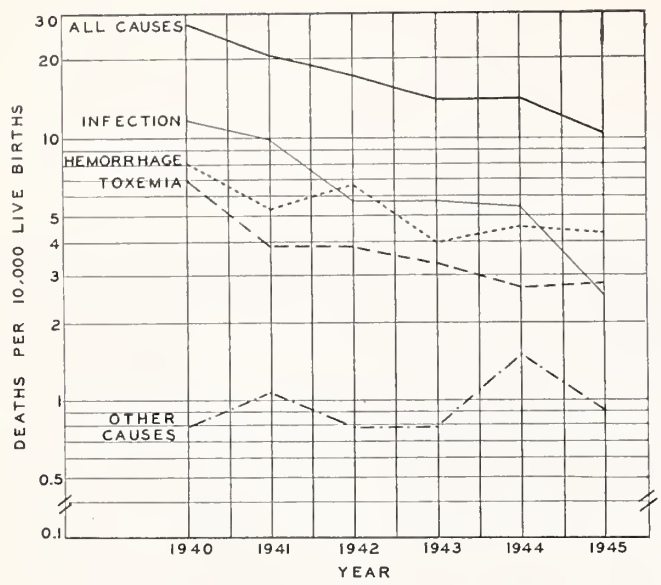


CHART 2

Maternal death rates by principal causes: Connecticut, 1940-1945

penicillin. Although a reduction has also occurred from hemorrhage and toxemia, we in Connecticut have seen no change in the past two years in deaths from these causes.

TABLE 1

CLASSIFICATION OF PRINCIPAL CAUSES OF MATERNAL DEATHS AND NUMBERS OF DEATHS: CONNECTICUT, 1940-45

	INTERNATIONAL LIST NUMBERS	NO. OF DEATHS
Infections	140 (all)	
	142 a	126
	145 A	
	147 (all)	
Toxemias	141, a, c	
	144 (all)	73
	148 (all)	
Hemorrhage and Shock	141 b	
	142 b	
	143 (all)	103
	146 (all)	
	149 (all)	
Other Causes	141 d, e, f	
	150 (all)	19
	145 B	
Non Puerperal	.....	54
Total		375

TABLE 2

The number of deaths from infection are 126, from toxemias 73, from hemorrhage and shock 103, and other causes 19. There were 54 deaths which were non puerperal, making a total of 375.

In addition to 321 cases classified under International List Numbers 140-150, there were 54 cases reported as having been pregnant at the time of death, or within three months prior to death which were assigned according to the survey to non puerperal causes. They are as follows:

I. INFECTIOUS AND PARASITIC DISEASES
- 13 (b) Pulmonary Tuberculosis 2
- 14 Tuberculosis of the meninges 1
- 22 (a) Miliary tuberculosis 2
- 36 Acute poliomyelitis 1

II. CANCER AND OTHER TUMORS
- 47 (d) Cancer of the lung 1
- 50 Cancer of the breast 2
- 56 (a) Non malignant tumor of ovary 1
- 56 (b) Non malignant tumor of the uterus 1
- 56 (d) Brain tumor (meningioma) 1

IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS
- 72 (a) Primary purpuras 2
- 74 (a) Chronic myelogenous leukemia 2

VI. DISEASES OF THE NERVOUS SYSTEM
- 80 (a) Intracranial abscess 2
- 83 (a) Cerebral hemorrhage 1
- 89 (b) Diseases of the mastoid process 1

VII. DISEASES OF THE CIRCULATORY SYSTEM
- 92 (b) Diseases of the mitral valve 1
- 92 (c) Chronic rheumatic endocarditis 3
- 92 (d) Endocarditis not specified as rheumatic 4
- 93 (b) Myocarditis 1
- 93 (d) Chronic myocarditis not specified as rheumatic 1
- 95 (a) Diseases of the coronary artery 1
- 95 (b) Other diseases of the heart, specified as rheumatic 4

VIII. DISEASES OF THE RESPIRATORY SYSTEM
- 107 Broncho-pneumonia 2
- 108 Lobar pneumonia 3
- 114 (d) Mediastinal abscess 1

IX. DISEASES OF THE DIGESTIVE SYSTEM
- 121 Acute appendicitis 3
- 122 Intestinal obstruction 4

X. DISEASES OF THE GENITO-URINARY SYSYTEM
- 131 (b) Chronic nephritis (other than arterio sclerotic) 3

XVII. VIOLENT OR ACCIDENTAL DEATHS
- 163 (A) Suicide by poisoning 1
- 170 (c) Automobile accident 1
- 186 (a) Accidental fall 1

According to the time of death, the major group falls into the period during or after delivery which institutes 71 per cent. The second largest group is during or after abortion, 15 per cent; before delivery, 10 per cent; and during or after ectopic gestation, 4 per cent.

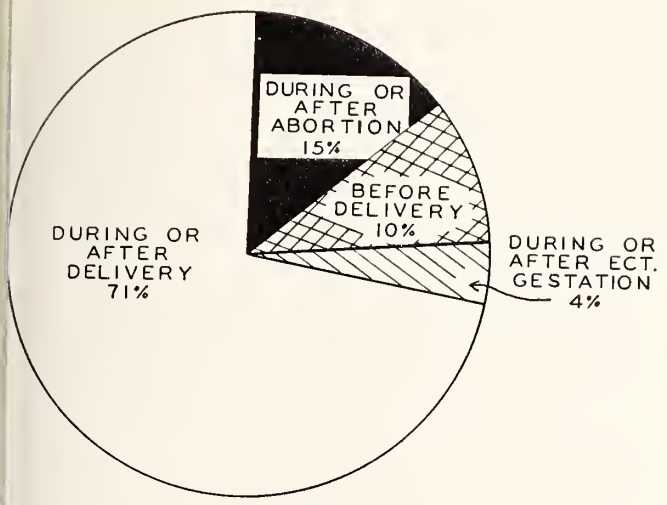


CHART 3
Maternal deaths in relation to time of death: Connecticut, 1940-1945

TABLE 3

MATERNAL DEATHS IN CONNECTICUT, 1940-1945; SURVEY FIGURES COMPARED WITH FIGURES FROM U. S. BUREAU OF CENSUS, 1940-44

YEARS	U. S. BUREAU OF THE CENSUS			MATERNAL MORTALITY SURVEY		
	NUMBERS OF BIRTHS	NUMBERS OF MATERNAL DEATHS	MATERNAL MORTALITY RATES*	NUMBERS OF BIRTHS	NUMBERS OF MATERNAL DEATHS	MATERNAL MORTALITY RATES*
1940	25,195	71	2.8	24,487	68	2.8
1941	28,526	56	2.0	28,105	57	2.0
1942	37,264	67	1.8	35,980	62	1.7
1943	39,005	63	1.6	37,748	53	1.4
1944	34,278	52	1.5	33,004	47	1.4
1945	—	—	—	32,423	34	1.0

*Rates per 1,000 live births

There is some discrepancy in the figures of the Census Bureau as compared with those of the survey during the past few years due to the fact that the Census Bureau includes Connecticut residents allocated from other states, and in addition, the deaths will differ since in the survey additional information was available.

No statistics are available for the country as a whole for 1945, but previous to that year infection was the leading cause of death, with hemorrhage second. In Connecticut, infection now has dropped to third place in the rating of maternal deaths. This is the first year that this change has occurred. The decrease in the number of deaths from infection, due to several factors, can also be instituted in the reduction of deaths from hemorrhage and also toxemias. In reviewing the deaths during the past few years, it is quite evident that in many of the hospitals, especially the smaller ones, whole blood is not available for the treatment of hemorrhage. The emergency use of glucose, saline solution, and plasma is not enough to save many of these women. It is only by the replacement of whole blood that we may expect a reduction in the number of these deaths.

TABLE 4

NUMBER OF MATERNAL DEATHS AND DEATH RATES* BY PRINCIPAL CAUSES: CONNECTICUT, 1940-1945

CAUSES OF DEATH	TOTAL DEATHS	RATES PER 10,000 LIVE BIRTHS					
		1940	1941	1942	1943	1944	1945
All Causes	321	27.8	20.3	17.2	14.1	14.2	10.5
Infections	126	11.8	10.0	5.8	5.8	5.5	2.5
Toxemias	73	7.0	3.9	3.9	3.4	2.7	2.8
Hemorrhage	103	8.2	5.4	6.7	4.0	4.6	4.3
Others	19	0.8	1.1	0.8	0.8	1.5	0.9

*Based on live births reported by Bureau of Vital Statistics, Connecticut State Department of Health

Puerperal hemorrhage calls for blood immediately. There is little time to send for donors, and the necessary delay of typing before transfusion. The establishment of blood banks in all hospitals will be a great step forward in the improvement of these statistics.

It is noted frequently that patients die with a moderate loss of blood. The determination before delivery of the percentage of hemoglobin, and the red count is essential in order that we know whether or not transfusion shall be indicated before, during, or after delivery. Since the deaths from hemorrhage have changed very little during the past few years, it is a challenge to the hospitals and physicians in Connecticut to overcome this problem by some plan in which a supply of blood is available to all hospitals, large and small, throughout the state. The blood donor service of the Red Cross may be the answer to this problem.

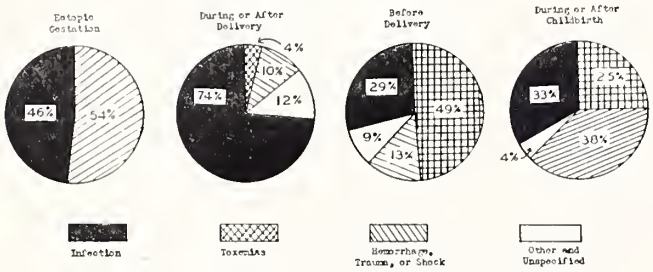
Toxemias now rank second as the cause of death, and this rate can be reduced materially by the education of the public to apply for prenatal care early in pregnancy, by the conscientious care of these patients by the physician, and hospitalization with the first sign of impending danger. A review of the cases during the past six years shows that many patients are admitted to the hospital without pre-

natal care, or with rather uncertain attention during this period. The slight increase in deaths from 1944 to 1945 would indicate that we are not meeting this problem as we should.

Connecticut is well supplied with prenatal clinics, and due to the economic condition of this state, many more can afford to visit their physician early in pregnancy. There is no reason why we cannot cut this rate down far below what it is at the present time.

CHART 4

Maternal deaths by cause, in relation to time of death: Connecticut, 1940-1945



ECTOPIC GESTATION

Total	13	100%
Infection	6	46%
Hemorrhage	7	54%

DURING OR AFTER ABORTION

Total	49	100%
Infection	36	74%
Hemorrhage	5	10%
Toxemia	2	4%
Others	6	12%

BEFORE DELIVERY

Total	31	100%
Infection	9	29%
Toxemia	15	49%
Hemorrhage	4	13%
Others	3	9%

DURING OR AFTER CHILDBIRTH

Total	228	100%
Infection	75	33%
Toxemia	56	25%
Hemorrhage	87	38%
Others	10	4%

During or after abortion accounted for 49 cases in which infection occurred in 36, or 74 per cent. However, before delivery, toxemia ranks first wi 49 per cent out of the total of 31 cases, infecti appearing second in 29 per cent, and hemorrhag 13 per cent. The largest group are those whi occur during or after childbirth, totalling 228, a here again we see hemorrhage appearing as the for most cause of death, 38 per cent; infection, 33 p cent; and toxemia, 25 per cent.

The large number of cases dying from infecti in spite of the reduction during the past two yea would indicate an insufficient use of chemotherap in the prophylactic and curative treatment of the individuals. The larger group, i.e., those during after abortion comprise 74 per cent of the tot causes of all deaths in that group, could be reduce by the prophylactic use of the modern drugs. Eve in the case of spontaneous abortion, the use penicillin would reduce considerably the mortalit and morbidity in this group.

One so often sees cases of incomplete abortion i which a curettage is done for removal of retaine seccundines, and temperature follows, evidence pelvic infection. The routine use of these drugs i all cases of abortion will prevent these accident which are all too common. The prophylactic us also of the antibiotics in prolonged labor is essentia especially in cases in which membranes have rup tured early. This would materially reduce those in fections occurring before, during, and after child birth.

The type of delivery has a definite relationship t maternal mortality, and Table 5 demonstrates clear ly the instances and the number of deaths occurrin with these various procedures.

Cesarean section ranks first with 21.8 per cent o deaths, 33 of these occurring from hemorrhage; 2

TABLE 5

TYPE OF DELIVERY BY PRINCIPAL CAUSES OF DEATH: CONNECTICUT, 1940-1945

PRINCIPAL CAUSES	TOTAL	CESAREAN SECTION	VERSION, VERSION-EXTRACTION	HIGH OR MID-FORCEPS	LOW FORCEPS	FORCEPS PLANE UNSPECIFIED	OTHER OPERATION	*INAPPLICABLE
All Causes								
Number	321	70	19	21	27	3	18	163
Per cent	100.0	21.8	5.9	6.6	8.3	1.0	5.6	50.3
Infections	126	25	3	7	11	2	9	69
Toxemia	73	12	1	9	7	0	2	42
Hemorrhage	103	33	15	5	8	1	7	34
Others	19	0	0	0	1	0	0	18

*Includes 86 with no operation, 5 not reported, and 72 undelivered or criminal abortions

from infections; and 12 from toxemias. The increase in the number of cesareans and the discrepancy in the number of cesareans performed in various hospitals throughout the State deserves considerable study. In one hospital during 1945-1946, the cesarean rate was 8.6 per 1,000 deliveries. In another hospital, the rate was 122.8 per 1,000 deliveries. Both of these institutions have fairly large obstetrical services. The stillbirth rate in these two hospitals differs very little. According to the study, 6.6 per cent of these deaths occurred in patients who were delivered by high or mid forceps. There is some question as to whether or not high forceps were used in these cases. The use of high forceps on a floating head is not considered good obstetrics in these modern days.

TABLE 6

AVERAGE YEARLY MATERNAL DEATHS AND DEATH RATES* ACCORDING TO AGE OF MOTHER: CONNECTICUT, 1940-1945

AGE	LIVE BIRTHS	AVERAGE YEARLY MATERNAL DEATHS	
		NUMBER	RATES*
Total	39,005	54	13.8
10-14	9	0	—
15-19	1,838	2	10.9
20-24	10,961	9	8.2
25-29	13,761	14	10.2
30-34	8,143	15	18.5
35-39	3,461	10	28.8
40-44	736	4	54.2
45-49	35	0.5	142.8

*Rates per 10,000 live births based on live births reported by the Bureau of the Census for 1943

Age is an important factor in maternal deaths and the accompanying Table 6 shows the average yearly maternal deaths and death rates according to the age of the mother. It is noted that during the period 1940-1945, there were only nine births in mothers between the ages of 10 and 14, with no deaths. The number of births increased to the maximum for the ages between 25 and 29. However, the maternal mortality rate continued to increase thereafter until a point was reached at the ages 45-49 when the death rate was 142.8 per 10,000 live births. The experience throughout the United States is a high mortality rate among the very young, and an increasing rate from 29 to 49 years of age. The high death rate among the young is probably due to the immature physiological development of these children, and the deaths among the older individuals are due to complicating diseases which increase in severity over a period of years and also to the fact that, as the survey shows, women who have had many children without difficulty are apt to neglect prenatal care as time goes on. Our attention, therefore, is drawn to these figures in order that we may include in our program some procedure to meet this problem.

Figures published for the United States as a whole from 1933 to 1943 show a maternal death rate in that age bracket of 15-19 of 21.7, whereas in Connecticut it was 10.9.

TABLE 7

PERCENTAGE DISTRIBUTION* OF LIVE BIRTHS AND MATERNAL DEATHS BY AGE OF MOTHER: CONNECTICUT, 1940 1945

AGE	LIVE BIRTHS	PER CENT	MATERNAL DEATHS	PER CENT
Totals	39,005	100	321	100
10-14	9	(a)	0	—
15-19	1,838	4.7	12	3.7
20-24	10,961	28.1	56	17.5
25-29	13,761	35.3	81	25.2
30-34	8,143	20.9	89	27.8
35-39	3,461	8.9	59	18.4
40-44	736	1.9	21	6.2
45-49	35	(a)	3	.9

*Based on live births reported by U. S. Bur. of Census, 1943 and maternal deaths reported by Study Comm. 1940-45.
(a) less than 0.5 of one per cent.

Table 7 shows the percentage distribution of live births and maternal deaths by the age of the mother. In this chart we have used the Connecticut births of 1943 by the U. S. Census Bureau and the maternal deaths by study figures of 1940-45.

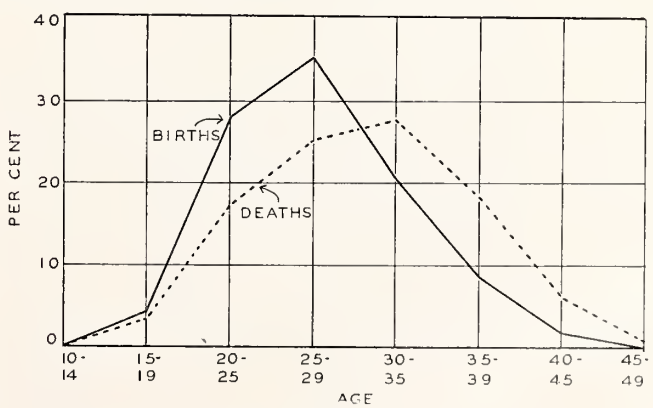


CHART 5

Maternal Mortality Rates by Age of Mother: Connecticut, 1940-1945*

*Figures based on 1943 births reported by the U. S. Bureau of the Census and the average yearly number of deaths, 1940-1945 reported in the study

Chart 5 shows the gradual increase in maternal mortality with the increase in age.

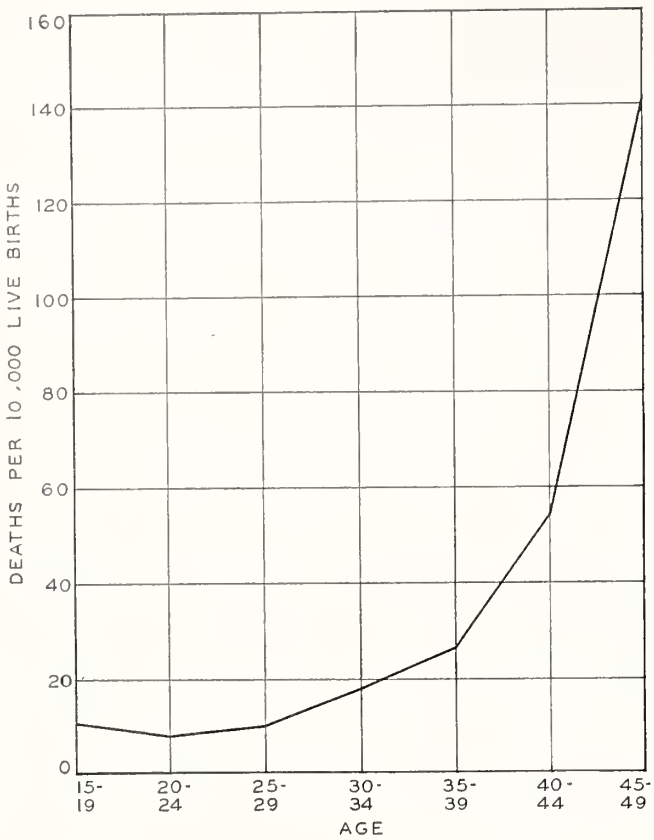


CHART 6
Percentage Distribution of Live Births and Maternal Deaths by Age of Mother: Connecticut, 1940-1945*

*Figures based on 1943 births reported by the U. S. Bureau of the Census and the average yearly number of deaths, 1940-1945 reported in the study

Chart 6 shows the percentage distribution of live births and maternal deaths by the age of the mother, 1940-45. Again the births are figures from the U. S. Census Bureau for 1943 and the maternal deaths from the Connecticut Study, 1940-1945. This demonstrates that while the majority of births occur among younger mothers, the larger number of deaths occur among the older mothers.

Table 8 shows the period of gestation when women delivered or died, according to parity. Those dying in pregnancy of less than 8½ months fall into two major groups—the para 9 and over, and the para 2. The figure occurring among the older group can be accounted for by complications and insufficient prenatal care. The death rate at term, as might be expected, is highest among the primipara. It is interesting to note that at term, the percentage of deaths occurring in multiparae falls off due to the fact that if these women reach full term, the complicating illness is probably well compensated.

TABLE 8

PERIOD OF GESTATION WHEN WOMEN DELIVERED OR DIED, ACCORDING TO PARITY: CONNECTICUT, 1940-1945

	REPORTING		LESS THAN 8½ MONTHS		TERM OR POST-PARTUM		NO
PARITY	NO.	PER CENT	NO.	PER CENT	NO.	PER CENT	REPOI
Total	300	100	128	43.0	172	57.0	21
Para. 1	116	100	36	31.0	80	69.0	6
Para. 2	52	100	29	56.0	23	44.0	4
Para. 3	49	100	18	38.0	31	62.0	2
Para. 4-8	50	100	24	48.0	26	52.0	2
Para. 9 and over	13	100	7	54.0	6	46.0	0
No Report	20	100	14	70.0	6	30.0	7

TABLE 9

MATERNAL MORTALITY BY PLACE AND ATTENDANT: CONNECTICUT, 1940-1945

	DEATH IN HOSPITAL		DEATH NOT IN HOSPITAL	
	NUMBER	PER CENT	NUMBER	PER CEN
Total	299	100.0	22	100.0
Delivered in hospital by physician	223	74.6	9	40.9
Delivered in home by physician	6	2.0	2	9.1
Delivered in home not by physician	34*	11.4	3	13.6
Not delivered or inapplicable	34	11.4	8	36.4
Delivered on way to hospital	2	.7	0	—

*29 of these were abortions.

Maternal mortality according to place and attenc ant indicates that the largest number of these deatl occurred in the hospital and were delivered b physicians. However, since the number of patien delivered in hospitals in Connecticut is 97.9 per cen it will be expected that the high death rate woul occur in hospitals. It is universally admitted in thes modern days that the safest place to be delivered in a well equipped hospital. Among other facto that have contributed to the reduction of matern mortality in the northern states is the ever increasin number of women going to hospitals for delivery The deplorable conditions existing in the Sout among the negroes under the care of incompeter midwives, delivered in their crude homes, is one c the reasons for the high rate in that area. As mo and more people are admitted to hospitals for d livery under aseptic conditions and under the supe vision of competent obstetricians, the maternal deat rate will decrease markedly. In 1923 there wer

,488 deliveries in Connecticut by midwives, or a ercentage of total deliveries of 14.5 per cent. At iat time, 110 midwives were registered. During 945 the number of registered midwives was 44, and ie total number of deliveries by midwives was 9, r less than 0.1 per cent.

Table 10 shows the considerably high percentage f deaths from ectopic pregnancy as a result of ifection and the relatively high proportion of ifections in abortion. One would assume that the ercentage of toxemia in these cases of abortion would be somewhat higher. 29.1 per cent of the ases studied died of infection before delivery and iere again the emphasis is placed on the use of enicillin and other antibiotics. Although the lecline of deaths from infection has been dramatic luring the past two years, the overall picture shows hat the percentage of patients dying from infection luring and after childbirth to be 32.9 per cent.

In an article by Doctors Davis and Gready of the Chicago Lying-In Hospital, in the April issue of the *American Journal Obstetrics and Gynecology*, they showed that since 1939, 20,000 women were delivered without a single death due to puerperal infection. There is hope that with the proper care of these patients, deaths from infection can be reduced materially within the next few years.

The ultimate outcome in the care of the patient is shown in Table 11 with the length of labor as a contributing factor in cause of death, and here again we note that forty of these patients were in labor twenty-four hours or over. Seventeen of them died from infection and sixteen from hemorrhage and shock, both of which might have been combated with appropriate treatment.

TABLE 11

LENGTH OF LABOR BY PRINCIPAL CAUSE OF DEATH: CONNECTICUT, 1940-45

CAUSE OF DEATH	TOTAL	HOURS OF LABOR 0-3	4-23	24 OR OVER	NO LABOR	UNKNOWN OR UNDELIVERED
All Causes	321	33	99	40	46	88
Infection	126	11	30	17	15	46
Toxemia	73	7	33	5	8	17
Hemorrhage or Shock	103	11	34	16	23	15
Other	19	4	1	2	0	10

TABLE 10

MATERNAL DEATHS BY CAUSE, IN RELATION TO TIME OF DEATH: CONNECTICUT, 1940-1945

CAUSE OF DEATH	TOTALS NO.	TOTALS PER CENT	DURING OR AFTER ECTOPIC PREGNANCY NO.	DURING OR AFTER ECTOPIC PREGNANCY PER CENT	DURING OR AFTER ABORTION NO.	DURING OR AFTER ABORTION PER CENT	BEFORE DELIVERY NO.	BEFORE DELIVERY PER CENT	DURING OR AFTER CHILDBIRTH NO.	DURING OR AFTER CHILDBIRTH PER CENT
All Causes	321	100.0	13	100.0	49	100.0	31	100.0	228	100.0
Infections	126	39.2	6	45.6	36	73.5	9	29.1	75	32.9
Toxemias	73	22.8	—	—	2	4.1	15	48.3	56	24.6
Eclampsia	37	11.5	—	—	—	—	8	25.8	29	12.7
Albuminuria and Nephritis	23	7.2	—	—	—	—	6	19.3	17	7.5
Other Toxemias	13	4.1	—	—	2	4.1	1	3.2	10	4.4
Hemorrhage, Trauma or Shock	103	32.1	7	54.4	5	10.2	4	12.9	87	38.2
Other and Unspecified Causes	19	5.9	—	—	6	12.2	3	9.7	10	4.4

TABLE 12

TYPE OF DELIVERY ACCORDING TO LENGTH OF LABOR AND PARITY OF WOMAN IN 207 REPORTED CASES

TYPE OF DELIVERY	PRIMIPARA TOTAL REPORTED	PRIMIPARA HOURS OF LABOR 0-3	4-23	24 OR OVER	MULTIPARA TOTAL REPORTED	MULTIPARA HOURS OF LABOR 0-3	4-23	24 OR OVER
Total	93	18	52	23	114	51	47	16
Spontaneous	18	2	15	1	46	16	25	5
Operative	74	16	37	21	64	33	21	10
Cesarean	29	13	10	6	30	22	4	4
Forceps	33	1	21	11	18	2	13	3
Others	12	2	6	4	16	9	4	3
Undelivered	1	0	0	1	4	2	1	1

The high mortality rate among patients delivered by cesarean is due in so many instances to a prolonged test of labor. In Table 12 we note that among

primipara, six cases had been in labor over twenty-four hours before a section was done, and in the multipara, four patients died having been in labor over twenty-four hours before a section.

In many of the hospitals in Connecticut a rule is in existence whereby a patient in the hospital for twenty-four hours must have consultation. If this rule were in effect in all hospitals and carried out, many of these complications could be avoided.

TABLE 13

TIME OF DEATH IN RELATION TO DELIVERY ACCORDING TO PRINCIPAL CAUSES OF DEATH: CONNECTICUT, 1940-1945

CAUSE OF DEATH	TOTALS	BEFORE OR DURING DELIVERY	AFTER DELIVERY				
			LESS THAN ONE DAY	1 TO 13 DAYS	14 DAYS AND OVER	INTERVAL NOT STATED	NO REPORT
All Causes	321	49	86	124	42	7	13
Infection	126	14	8	52	36	5	11
Toxemia	73	17	20	32	3	0	1
Hemorrhage	103	12	55	33	1	1	1
Others	19	6	3	7	2	1	0

Table 13 demonstrates the time of death in relation to delivery, according to the principal cause of death. The number of deaths from hemorrhage soon after delivery, and infection after a longer interval are significant, the emphasis again placed on the free use of whole blood and the use of those drugs which are so valuable in combating infection.

TABLE 14

NUMBER OF MATERNAL DEATHS AND DEATH RATES* BY PRINCIPAL CAUSE OF DEATH AMONG 235 CASES REPORTING PLURALITY OF BIRTH: CONNECTICUT, 1940-1945

CAUSE OF DEATH	TOTAL DEATHS	SINGLE PREGNANCY		TWIN PREGNANCY		UNDELIVERED OR NO REPORT
		NO. OF DEATHS	DEATH RATES	NO. OF DEATHS	DEATH RATES	
All Causes	321	225	11.9	10	55.5	86
Infections	126	76	4.0	3	16.6	47
Toxemias	73	54	2.9	4	22.2	15
Hemorrhage	103	85	4.5	2	11.1	16
Other	19	10	.5	1	5.5	8

*Death rates per 10,000 deliveries, based on figures reported by Bureau of Vital Statistics, Connecticut State Department of Health

The death rate increases markedly in multiple pregnancies; the risk of twin pregnancies for all causes is 4½ times as great as for single pregnancies. Deaths from infection show about the same relationship, whereas from hemorrhage, the risk is abou 2½ times as great in twin pregnancies. Howeve deaths from toxemia show the risk to be 7¾ time as great in twin pregnancies.

TABLE 15

AGE DISTRIBUTION OF WOMEN DYING OF ABORTION WITH INFECTION: CONNECTICUT, 1940-1945

AGE OF MOTHER	TOTAL	ABORTION WITH INFECTION		
		SPONTANEOUS	SELF-INDUCED	CRIMINA
Total	36	8	14	14
15-19	5	1	3	1
20-24	10	1	4	5
25-29	9	3	3	3
30-34	4	0	2	2
35-39	4	1	1	2
40-44	4	2	1	1
45-49	0	0	0	0

Statistics are not available which would indicat the number of criminal abortions throughout th state or throughout the country, but in this serie there were fourteen criminal abortions, fourtee self-induced abortions, and eight spontaneous, witl infection. It is a difficult matter in some instance to determine whether or not these abortions ar spontaneous or self-induced, but in these days, th death of eight patients from spontaneous abortio should urge us to institute measures which in prac tically all instances would save these mothers. Ever in those self-induced and criminal types, many i the future will be saved.

This table indicates that most abortions occur i the age group, 20-24, although there were mor babies in the age group, 25-29.

TABLE 16

PRINCIPAL CAUSES OF DEATH ACCORDING TO BIRTHPLACE OF MOTHER: CONNECTICUT, 1940-1945

CAUSE OF DEATH	TOTAL	NATIVE BORN	FOREIGN BORN					
			BRITISH ISLES	AUSTRIA AND GERMANY	ITALY	CANADA	OTHER COUNTRIES	NO REPORT
All Causes	321	268	8	3	10	8	11	13
Infection	126	102	6	1	4	5	2	6
Toxemia	73	60	0	0	4	1	4	4
Hemorrhage	103	89	2	0	2	2	5	3
Other	19	17	0	2	0	0	0	0

It is interesting to consider the principal cause o death according to the birthplace of the mother i this series.

In the total study, the death rate per 1,000 live rths among native born was 1.3, and among foreign orn, 2.3. This may be accounted for by certain perstitions which exist in the minds of many of ese people, plus the neglect to consult a physician rly for prenatal care, and constitutional char-teristics of certain nationalities which tend to use difficult labors.

OMMENTS

In most surveys of maternal deaths, it is customary designate preventable and non preventable deaths. preventable, one infers that had some other rocedure been instituted, the outcome might have en different. In many instances it is quite evident at the obstetrical judgment on the part of the ysician was not good, but in so many cases one nnot judge definitely as to whether or not the tient would have lived had different care been ven.

In those patients who have not had adequate pre-tal care and are admitted to the hospital in con-lsions, we assume that the death was preventable d the patient utilized existing prenatal facilities.

In this group of 321 deaths, we have considered at 76 deaths were preventable had the physician ed different judgment, and 65 deaths were attrib-ed to the fact that the patient did not avail herself proper care. In most of the surveys conducted roughout the country, the conclusion is that two-irds of maternal deaths are preventable. A review, erefore, of these maternal deaths over a period of x years points to several weaknesses which are sily correctable.

During the past few years, the crowding of mater-ty departments in various hospitals has caused a laxation in the strict adherence to the Sanitary ode of the State of Connecticut. Whenever this curs, infection and epidemics are bound to exist. he first step, therefore, is to be certain that viola-n of the Sanitary Code does not occur.

As has been shown in these statistics, our biggest roblem is deaths from hemorrhage, and they can-t be overcome without the establishment of blood nks in all hospitals. The determination of the moglobin before delivery should be routine since patient with a moderate degree of anemia, who ses more blood at the time of delivery than the erage person, is in great danger, especially in ose hospitals where blood is not available for mediate transfusion.

The advantage of routine Rh determination has been brought to our attention repeatedly during the past few years, and in this series five patients died from transfusion with incompatible blood. We can prevent serious reaction to pregnant women if Rh determination are made routinely.

The early diagnosis of ectopic pregnancy, with early operation following treatment of the initial shock, and the use of large amounts of blood, will do much to reduce this appalling death rate. In these cases of excessive hemorrhage, one transfusion of a pint of blood is not sufficient. Repeated transfusions assure us of better results.

Placenta previa and premature separation are taking a fairly large toll, and the method of treatment varies in different instances. The use of x-ray has helped considerably in the diagnosis of placenta previa, and in some cases it eliminates the dangerous vaginal examination which would aggravate the hemorrhage. No vaginal examination in placenta previa should be done unless we are prepared to do a cesarean section immediately. If one finds on a vaginal examination that he is dealing with a marginal previa or a low implantation, rupturing of the membranes allowing the head to drop down and tampon the edge of the placenta often is sufficient, but when examination shows central placenta previa, the procedure of choice is cesarean section. In this series, the attempt to deliver from below in central previa has resulted in death.

In abruptio placentae, two types of treatment are utilized in our State. First, the conservative in which the vagina is packed tightly, a Spanish windlass applied, and minim doses of pitocin used for induction of labor. This method was first instituted in Dublin at the Rotunda Hospital, and popularized in this country by Dr. F. C. Irving. The more radical treatment is that of cesarean section where one may visualize the condition of the uterine muscle to determine whether infiltration of blood in the musculature of the uterus prevents uterine contractions, and where hysterectomy may be performed where uterine contraction does not occur.

The type of delivery in those cases which had had a previous cesarean is still debatable in the minds of many. There are those who say "once a cesarean, always a cesarean," and others who feel that if no morbidity occurred with the previous section, delivery from below is possible unless there is serious disproportion. In this series there were eleven cases of ruptured uterus, three of which occurred in cases

which had previous sections. It would seem that the risk is too great to allow all patients who had had previous cesareans to be delivered from below when one does not know the condition of the scar in the uterus.

In the April issue if the *Journal of Obstetrics and Gynecology*, Doctors Davis and Gready, in analyzing their cases, found that 16 per cent of puerperal deaths were cardiac. In our series it was found that those patients dying before, during, or after delivery, in forty or 10.7 per cent, cardiac conditions were present. However, in only twenty-five was the heart disease a contributing factor, and in fifteen, not a contributing factor. The rather high percentage of cardiac deaths in pregnant women should make us more conscious of the fact that these patients should be under the care of a clinician who should prepare the heart for the stress and strain of labor if at all possible. This also applies to other medical complications that exist during pregnancy. The obstetrician should be willing to turn over the patient to a competent internist for the treatment of these diseases, knowing that with the improvement in the general health of the patient, the possibility of safer delivery is assured.

It is only by the constant education of the public and profession on the value of adequate prenatal care that we shall be able to reduce the number of deaths occurring from toxemia. Knowing as we do that eclampsia can arise in a very short time, it behooves the physician to see his patient frequently during the last two months of pregnancy. Emphasis is also placed on early hospitalization and consultation at the first signs of toxemia. For many years it has been proven conclusively that the conservative treatment of eclampsia is best. Active interference in a patient with convulsions will in most instances result in the death of the patient. The primary object, therefore, should be the treatment of the toxemia, disregarding for the moment the delivery.

As has been shown in this series, the number of cases dying from infection is rapidly declining. Having at hand such formidable drugs as the sulpha group, penicillin and streptomycin, it is possible now to further reduce this number of deaths. The procedure in the past has been to wait until evidence of infection occurs, and then to use large doses of these drugs to overcome the infection. The prophylacti use of these anti-biotics is much more important. A mentioned previously, deaths occurring in spontane ous abortion are probably due to retained produc of conception over a period of time with ascendin infection from the vagina. The routine use of thes drugs even in spontaneous abortion will eliminat practically all of these deaths. The prophylactic us in cesarean section and in protracted labors, espe cially with ruptured membranes also should be factor in the reduction of morbidity and mortality

Deaths from anesthesia in most cases are unavoid able, and in this series eight women died attributabl to anesthesia. One of these was a caudal death, on from spinal anesthesia, two occurred under cyclo propane, and four from aspiration of vomitu during anesthesia.

The discrepancies that have arisen in the diagnosi as specified on the death certificate and those a found in the survey would indicate that a mor active effort should be made to procure autopsies. I this series, autopsies were performed in just ninety eight or 30.6 per cent whereas no autopsies wer performed in two hundred and seventen, or 67.6 pe cent (not stated, 6 cases, or 1.8 per cent). If we ar to have more accurate figures as to the actual caus of death, more autopsies must be done. The larg number of cases signed out as pulmonary embol emphasizes this particular point.

And finally, a caution as to the designation o cause of death on the death certificate. In all cases i which pregnancy exists, it must be mentioned, bu unless the pregnancy contributes to the death, th actual cause of death should be mentioned, wit pregnancy second.

CONCLUSIONS

An analysis of 321 maternal deaths occurring i Connecticut during the years 1940-1945 inclusive i presented. Suggestions have been made of method for lowering the death rate to an irreducible mini mum. Cooperation by the State Health Department hospitals and physicians can make this possible. A challenge confronts us. Let us meet it so that fiv years from now we may report a maternal mortality rate of five per 10,000 live births.

OBSERVATIONS ON THE MANAGEMENT OF CANCER IN CONNECTICUT

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DURING the past year a study[1] was made of all cancers of the rectum admitted to 27 general hospitals in Connecticut from 1935 to 1945 inclusive. A program whereby hospitals forward to the Division of Cancer Research of the State Health Department standardized clinical records of all patients with cancer made such a report possible. The records come from both large and small hospitals comprising approximately 95 per cent of the total general hospital beds of the State. Patients of all economic levels, indigent to private, are included and follow-up information is obtained on over 90 per cent of patients. Thus a cancer registry has evolved which is unique in its freedom from selectivity, and any analysis based upon it should reveal a more representative cross-section of clinical results being obtained by the country as a whole, than similar studies from large teaching hospitals and private clinics which now constitute the major source of statistical data on cancer. In light of this study provocative observations may be made on operability, operative mortality, and curability rates.

In the 11-year period, 1935-1945, there were 1,610 patients admitted to Connecticut hospitals with a diagnosis of cancer of the rectum. Of this number, 1,188 (73.9 per cent) were proved by histologic examination, and in 422 (26.1 per cent) the diagnosis was only clinical. This proportion of unproved cases seems rather large and poses the question of how many cancers of other organs are never proved by microscopic examination. Until a histologic diagnosis of cancer is established in all cases, there will continue to be a group whose statistical validity is debatable, and it is not an unusual practice, therefore, to exclude unproved cases when analyses are being made. The justification for excluding or including unproved cases in any presentation depends ultimately upon the object of the study. Obviously, unproved cases would have no significance in a study concerned with the effectiveness of a certain therapeutic procedure. On the other hand, exclusion of unproved cases in determining operability rates and end-results might, under certain circumstances, cause a greater distortion of facts than if they were included. If proved cases in any series approximate 100 per cent, the problem is negligible, but if the percentage is relatively low, as in this series, unproved cases cannot be completely disregarded.

TABLE 1

CANCER OF THE RECTUM

Based on Records of 27 General Hospitals in Connecticut 1935 - 1945

DISTRIBUTION BY TREATMENT OF CASES UNPROVED MICROSCOPICALLY

None	187
Colostomy	214
Local excision	3
X-ray and radium	15
Miscellaneous	2
Not stated	1
	422

A study of the records of 422 patients with histologically unproved rectal cancer showed that they were all admitted in a late stage of the disease. No treatment whatever was given to 187 patients, and the remainder received only some form of palliation (Table 1). In no unproved case was radical resection performed. As a rule, in such patients the clinical diagnosis is apt to be fairly certain, and one is led to suspect that the margin of error was probably small. The suspicion is strengthened by examining the longevity curve of 220 unproved cases in the first six-year period, since it coincides almost exactly with a curve plotted for 67 proved untreated cases in the same series (Chart 1), as well as with

Presented at the meeting of the New England Health Institute, University of New Hampshire, June 17, 1947

Statistical data are from the registry of the Division of Cancer and Other Chronic Disease, Connecticut State Department of Health, Hartford, Connecticut

one drawn for 100 untreated rectal cancers in Massachusetts.[2]

It is highly desirable that increased efforts be made to encourage the establishment of anatomic proof in all cases of cancer. In the meantime, patients in whom a strong presumptive diagnosis of cancer can be made on the basis of roentgenographic examination or some equally authoritative diagnostic technique, should be accorded a measure of consideration, at least in an alternate total. Failure to do

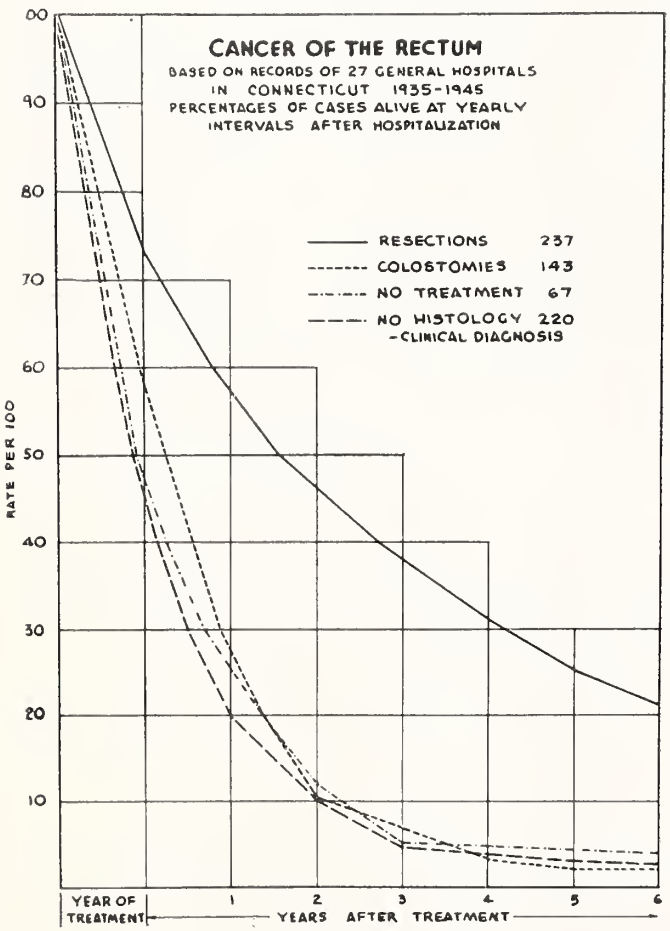


Chart I

so may, at times, obscure the very group which deserves critical analysis, and which forms the most fertile source of opportunities to improve salvage rates.

The effect of excluding unproved cases is apparent in determining Connecticut operability rates. Based upon proved cases only, the operability rate for this series of rectal cancer was 52.3 per cent, while if unproved cases are included, the rate drops to 38.6 per cent, both of which are below those reported from many large clinics (Chart II). It should be pointed out that because of the complex ity of contributing factors, reported operabilit rates are not always strictly comparable. They ar affected by the attitude of the surgeon towar performing radical operations in the presence c extensive disease, or on patients whose general cor dition makes them doubtful risks. Also high opera bility rates may be due to the relatively sma number of patients in a late stage of the disease com monly directed to a given clinic. As a general rul

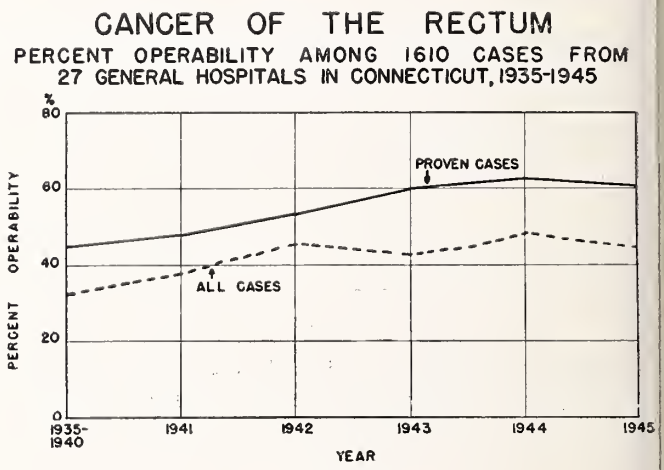


Chart II

however, operability rates may be expected to ris as the surgeon's experience with a particular opera tive procedure increases.

While the operability rate in Connecticut fo histologically proved cases was 52.3 per cent, th disease was classified as being localized (stage I in 59.5 per cent, and as showing only regional in volvement (stage II) in 26.6 per cent of cases Remote metastases on admission were found in 13.(per cent of cases. The possibilities for a highe operability rate are at once apparent, and it seem fair to assume that either the stages of the disease were erroneously recorded, or that in some in stances, where only palliative treatment was given resections might have been attempted by surgeon with greater experience in radical surgery fo cancer.

In Connecticut, although the operative mortality rate for the last five years was considerably lowe than for the first six years, it was 20.9 per cent fo the entire 11-year period. This, too, does not com pare favorably with reports from large institutions A death was considered to be postoperative if th patient died in the hospital, regardless of the time after operation. General agreement on a uniform

ethod of designating what constitutes an operative eath is needed, since it is well known that different iteria are used although they are seldom defined. is doubtful, however, if lack of a standard iterion to establish a death as operative accounts r wide discrepancies in reported rates.

Operative mortality rates in surgery for cancer ave been declining rapidly because of a broader nderstanding of measures for the prevention and anagement of shock and phlebitis, and the proved fectiveness of the antibiotics in combating many reviously fatal complicating infections. The emer- nce of the anesthetist from the status of a casually ained physician or technician to that of a recog- ized specialist, and advances in surgical techniques ave also influenced the decline. If all these factors e combined with wide experience in dealing with ecific types of malignant disease, conditions be- me ideal for the lowest possible operative mortal- y rate.

Unfortunately these conditions are not always sily fulfilled. For one thing, the very cancers hich require highly specialized treatment are not ncountered often enough by the average general rgeon to afford him an opportunity to acquire miliarity with them. In the whole State of Con- ecticut, for example, the yearly average of new ses of rectal cancer was 108, and these were dis- ersed among 27 hospitals and many surgeons. An bvious solution of the problem would seem to be e creation of a plan which would provide for the location of the less common and more technical rocedures to a fewer number of hospitals and sur- eons. At first thought such a possibility seems im- ractical. However, there is a growing tendency for rge institutions to become "parent" hospitals for naller ones in adjacent communities, so that hos- itals unable to render full time service in the basic elds of pathology, bacteriology and radiology, are covered" on a part time basis by the "parent" hos- ital. The affiliation of "daughter" with "parent" ospitals is becoming closer and closer to their utual benefit, as well as to their communities. At e present time, cases which fall into such limited ecialties as neurosurgery, thoracic surgery, etc., re managed by the "parent" hospital. Within such framework the special assignment of the more omplicated therapeutic procedures for cancer is oth logical and feasible. It must be emphasized, owever, that the "parent" hospital should set the xample by having the courage to initiate this pro- gram within its own staff if full cooperation of smaller hospitals is to be gained and the real objec- tive obtained. This approach to the problem of operability and operative mortality rates has not received the consideration it deserves.

Table 2

CANCER OF THE RECTUM
FIVE YEAR SURVIVAL AND CURE RATES
(Based on Records of 27 General Hospital in Connecticut 1935 - 1940)

BASES	TOTAL CASES	SURVIVAL RATES	CURE RATES
Total Admissions	735	12.8%	7.9%
Total Proved Cases	515	16.5	11.2
Proved Determinate Cases	503	16.9	11.5
Total Resections	237	25.3	15.6
All Resections Excluding Cases With Remote Metastases	214	26.6	17.3
All Cases Surviving Resection	178	32.0	20.8
Survivals of Resection Excluding Cases With Remote Metastases	161	35.4	23.0

In regard to curability and survival rates, there is a great deal of confusion, and much of it stems from failure to conform to a sound and uniform system of reporting statistical data. This is true to such an extent that it is dubious if an accurate impression of end-results can be derived from the current literature on malignant disease. The tendency to report results on selected cases may have great educational value in demonstrating what can be accomplished under optimum circumstances, but if this is done at the expense of clouding the total picture, attention may be diverted from basic realities. It has become increasingly difficult to determine the actual cure rate for all cancers of any one organ.

An example of the fluidity of results which may be claimed can be seen in this study of rectal cancer. The accompanying table shows that five-year cure rates vary from 7.9 per cent to 23 per cent, as the basis for computation becomes more and more selective. Five-year survival rates range from 12.8 per cent to 35.4 per cent when similarly estimated (Table 2). A simple and graphic method of showing overall results in the Connecticut study of rectal cancer is submitted below (Chart III). Percentages are based upon total admissions, but since proved cases occupy a separate column, percentages based upon them can be easily calculated if desired. It would be invaluable if a similar chart were submitted for cancers of all important organs.

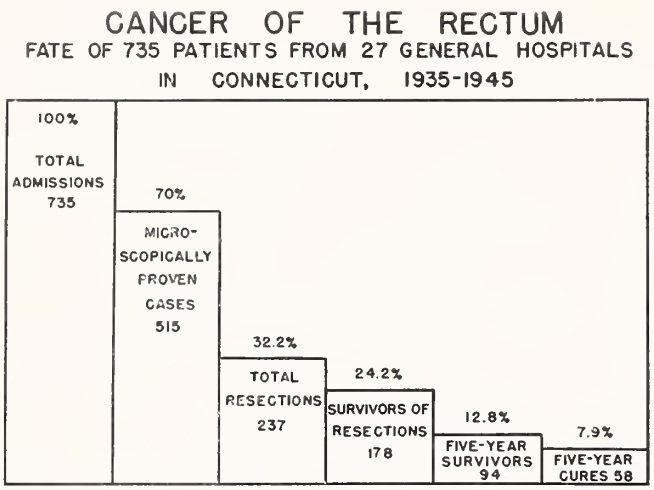


Chart III

There still remains the necessity for agreement upon criteria for determination of cure rates. The table below (Table 3) was made according to the method suggested by Dr. Hayes Martin who has long been a crusader for a uniform system of reporting end-results. It sets forth reliable criteria for determining cures, although all histologically unproved cases are excluded. Since the percentage of proved cases was relatively low in the Connecticut study, it seemed advisable to show, as a separate figure, the cure rate based upon total admissions. If Martin's table is used, it is obvious that follow-up information must be obtained in at least 90 per cent of patients.

Regardless of the method employed, if some uniformity in reporting results could be achieved, comparative studies would be more trustworthy and instructive. Nathanson[3] in a comprehensive review of the literature on end-results shows wide discrepancies in reports even from various large clinics, and concludes that "the method of calculation of end-results is probably the greatest single factor in accounting for differences in the reported figures." It may well be that the low cure rate for rectal cancer in Connecticut more nearly approximates the results generally obtained than the higher rates appearing in the literature. The question naturally arises if cure rates for other organs might not need downward revision if they also were calculated on a broad plane devoid of selectivity.

The study of rectal cancer in Connecticut suggests that much basic statistical research remains to

Table 3

CANCER OF THE RECTUM

Based on Records of 27 General Hospitals in Connecticut 1935 - 1940

FIVE-YEAR END RESULTS

Total number of histologically proved cases	515
Indeterminate Group:	
Dead as a result of other causes and without recurrence	10
Lost track of without recurrence	2
Total number of indeterminate results	12
Determinate Group:	
Total number minus those of indeterminate group	503
Failures:	
Dead as a result of cancer	420
Lost track of with disease (probably dead)	13
Living with recurrence	12
Total number of failures in treatment	445
Successful Results:	
Free from disease after five years or more	58
Five-Year End-Results:	
Successful results divided by determinate group— 58/503	11.5%
Successful results divided by total admissions (735) 58/735	7.9%

be done, particularly on State and national level if the problem of cancer is to be adequately defined. When the shortcomings and failures of the attack upon cancer are accurately located, educational effort may be directed where it is needed most urgently. State health departments by cooperating with State medical societies and general hospitals have an opportunity of making a fundamental contribution in this field. They have, as well, a responsibility to determine as completely as possible the status of cancer in their respective states.

The excellent beginning made by Connecticut should be an inspiration to other State health departments.

REFERENCES

1. Ottenheimer, E. J.: Cancer of the Rectum—An Analysis of Cases Occurring in Connecticut during 1935-1945. New England Journal of Medicine 237: 1-7, July 3, 1947.

2. Daland, E. M., Welch, C. E., and Nathanson, I. T.: One hundred untreated cancers of rectum. New England Journal of Medicine 214:451-568, 1936.

3. Nathanson, I. T.: Cancer: Results of Treatment. New England Journal of Medicine 229:468-480, September 16, 1943.

TERATOMA OF THE OVARY, REMOVAL WITH SUBSEQUENT PREGNANCY

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TERATOMA of the ovary, while not a rare condition, is still somewhat of a curiosity. Interest enhanced because it carries with it a very questionable, and in most cases a serious prognosis. Up 1945, there probably have been not more than 00 cases reported in the literature since the days f Virchow.[1] This does not include cases of teramas arising primarily in locations other than the vary: for example, the pineal gland, sacro-coccyeal region, and in other organs.

Teratoma is a tumor of complex congenital rigin, either embryonal in character and undifferntiated, or ranging all the way to fully mature dult structures and organs. In the German literare the word "teratoid"[5] is used in the sense that e ordinarily use teratoma, and they reserve the rm teratoma to describe a fully adult tumor with dult organs.

Probably the best classification of this type of mor is based on clinical knowledge and prognosis, e., benign and malignant.

Benign—(1) Cystic tumor-adult variety, often alled a dermoid tumor, comprising about 10 per ent of all ovarian tumors. Most dermoids consist f ectodermal elements such as skin, hair, sebaceous lands, sebum, teeth, and at times nerve tissue.

(2) Struma ovarii—a solid tumor consisting enrely of thyroid tissue. Some theorists take this roup out of the teratoma family, and put it in ith the aberrant thyroid group.

Malignant teratomas of the solid, or cystic and olid variety. Although a large part of this tumor ay be cystic, containing clear or hemorrhagic uid, there is a good deal of solid tumor tissue hich includes elements of all three germ layers in arying stages of development, from embryonal ells to fully developed structures and organs. Bedes the structures seen in the dermoid tumor, there ay be cartilage, bone, muscle and glandular strucres that resemble exactly those seen in adult astro-intestinal tract, bronchial tree, and endocrine lands. Brain tissue may be so differentiated that cerebral and cerebellar structures can be made out.[2] The gross and microscopic appearance rarely suggests malignancy, but subsequent progress of the cases indicate that they are more malignant than carcinomas or sarcomas of the ovaries. The mortality rate varies from 65 per cent to 88 per cent.[3,4] Curtis[1] states that they are potentially malignant in all cases, and undoubtedly malignant in most. When metastases or recurrences develop, they may consist of all types of cells seen in the orginal tumor, or as very often happens, one structure predominates in the malignant spread, and chorionepithelioma is very prominent in this group.[6]

A classification based on histopathology therefore, is quite useless and inadequate. It serves mainly to determine the type of tumor, and what structures are being formed. It is obviously impossible to serially section the entire solid portion of a large teratoma, and even this would be futile since the appearance of metastases under the microscope may have a "benign" appearance.[5] Unless numerous embryonal cells with marked anaplasia and numerous mitoses are found, or definite chorionepithelioma, histologically the tumor looks benign.

The origin of a teratoma is not known, but there are two theories to which most authorities ascribe. First, there is the sex cell theory in which by a process of parthogenesis, these sex cells may go on to attempt formation of another being. The second is the blastomere theory. In the early development of the individual, a blastomere, after the individual is formed, acts as a misplaced cell rest, and with a stimulus may begin to grow, and has inherent in it the capacity to form tissues of all three germinal layers. The dermoid and the thyroid tumors of the ovary are considered as a one-sided development of a teratoma. The relationship of teratomas to twins is interesting. A recent study[7] of a large group of these tumors and the related families, and a large control group showed that the incidence of twinning, whether measured by the percentage of families with twins, or by the ratio of twin births to total

births, is similar and consistently high in families of patients with ovarian dermoids, childhood teratomas, and with twin pregnancy, higher in each instance than in a random control group. This evidence would support a theory of the similarity in pathogenesis of teratomatous tumors and of twins, probably involving common factors of heredity.

Ovarian tumors in children account for half the non inflammatory masses in the abdomen seen in pediatrics. (Brenner). Of all the malignant tumors, teratomas are least frequent. Most of the teratomas of the ovary occur in children and young women. Pregnancy acts as a stimulus to light up a frequently unsuspected teratoma.[5]

The symptoms produced by an ovarian teratoma may be due to local growth, constitutional changes, or complications. These are:

(1) Increasing growth of abdomen with deformity.

(2) Mechanical effect by pressure on surrounding viscera.

(3) Constitutional disturbances, such as precocious sexual changes (not common).

(4) Complication, such as torsion of the pedicle. This occurs in about one-third of all cases, most commonly between the ages of 12 and 18.[8] A pedunculated teratoma eroded through the wall of the rectum in a colored woman.[9]

The treatment is surgical removal of the tumor. If metastases have already occurred, the situation is hopeless. Radiation therapy is useless, and has not served to reduce the mortality.[3] If no metastases are found at operation, should x-ray therapy be given? This is an interesting question, especially when viewed in the light of the case reported here.

CASE REPORT

J. C.—a white high school girl, age 16, was admitted to the Home Memorial Hospital, New London, on July 30, 1943. She gave a history of one day's duration. She felt nauseated and had moderate lower abdominal discomfort. On the morning of the day of admission, while getting out of bed, she developed pain in her lower abdomen, especially on the right side, radiating laterally above the right iliac crest, and posteriorly to the region of the right loin and sacro-iliac area. She vomited once.

The family history was irrelevant. There were no twins. She had had the usual childhood diseases, a tonsillectomy 10 years previous and an appendectomy 3 years previous. She began to menstruate at the age of 14. She considered herself in good health and felt entirely well up to the previous day. She denied sexual intercourse, and her menses had been perfectly regular, the last period having ended a week prior to admission.

On examination, she appeared to be in acute pain, lying with her knees flexed. She was well-developed and well-nourished. Temperature was 98.6, pulse 80, regular, and respirations 18. BP 126/74. All findings were normal, except for her abdomen. The liver and spleen were not palpable. No rigidity was present. Suprapubically there was a tender, elastic mass reaching almost to the umbilicus. There was also some tenderness over the right kidney area. Catheterization failed to reduce the size of the mass. On rectal examination, no stool was present, but a firm mass was felt occupying most of the cul-de-sac. There were no movements apparent in the mass, and abdominally no fetal heart could be heard.

Vaginal examination was done under anesthesia. The hymen was intact. This was gently dilated, and a small speculum inserted. There was a small amount of blood coming from the cervical os. A probe was inserted. It met slight resistance at the internal os, and then went in for a distance of 3 inches. The large mass seemed anterior to the uterus. The upper part was moveable, but the lower portion was fixed, and there was a hard bone-like feeling in the anterior cul-de-sac.

A scout x-ray film of her abdomen showed the outline of the mass, and there was a flat calcified sheet of bone extending from the left side of the pelvis over to the right of the midline.

A voided specimen of urine had gross blood in it. Hemaglobin was 80 per cent. Rbc., 4,840,000. Wbc., 10,300 with Polys., 75, Lymph, 18, Mono., 3, Eos., 2, Baso., 2.

A preoperative diagnosis of teratoma of the ovary was made and the patient was operated on August 2, 1943. She was first peritoneoscoped and a large cyst-like structure was found, filling the entire pelvis and arising out of it. It had a blue dome and was considered to be ovarian. Under nitrous-oxide-oxygen-ether anesthesia, a lower abdominal midline incision was made and the peritoneal cavity opened and explored. The right ovary was found to consist of multilocular cysts filled with clear fluid, but approximately half of the structure was made up of very firm and hard material. The ovary measured five to six inches in diameter. The veins of the right broad ligament were enlarged and some thrombosis, apparently from a torsion, was noted.

The uterus was infantile in size, the left tube and ovary were normal. The right ovary, including the right tube which was attached to it, was removed.

The postoperative course was uneventful, and the patient was discharged on the tenth postoperative day.

Pathological Report—The specimen consisted of a large cystic and solid tumor mass, measuring 18 x 12 cm. A Fallopian tube was stretched across the mass on the surface. The surface was relatively smooth, but there were several cystic bulbous protuberances containing clear fluid. The main tumor mass was composed of solid tissue measuring 12 x 8 x 6 cm. Imbedded within the grayish tumor were several small cysts containing clear fluid. There was a flat piece of bone 2 mm. thick, 4 cm. long, and 2 cm. wide near one end of the tumor and beneath this was a cyst containing a large amount of hair and sebaceous material.

Microscopic section showed cell types of all three germinal layers. Many of the cells were undifferentiated and immature, but in many areas definite structures could be made out. Besides the bone, there was cartilage, hair follicles, sebaceous glands, skin, glandular arrangements not unlike those seen in the intestine, striated muscle, fat cells and nests of lymphocytes. Epithelium resembling that seen in the bronchus could also be made out. The diagnosis was teratoma of the ovary. This diagnosis was concurred in by Dr. H. S. N. Greene of the Department of Pathology of the Yale University School of Medicine, who reviewed the slides.

Subsequent Course—Following her discharge from the hospital she was checked at intervals of 2 to 4 months. She remained well except for an occasional cold, but had no symptoms referrable to her original condition. She was married in October 1945, and her condition was excellent in January 1946. In March 1946, she reported her last period as having occurred on January 6, and definite signs of pregnancy were made out. She was followed very carefully during her pregnacy, and in October, 1946, she gave birth to a living female child in good condition, weighing 6 lbs. 5 oz., by outlet forceps and episiotomy. Her puerperium was uneventful and she was discharged from the hospital after 5 days. The last examination on Sept. 29, 1947 revealed her to be 5 months pregnant and feeling well.

DISCUSSION

Some of the features of this case fit in very well with the average case of its type. The occurrence of this tumor in a young girl, the torsion of the pedicle producing pain as the first symptom of its presence. This may have been a most fortunate occurrence being responsible for its surgical removal before the onset of metastatic spread. Nowhere in the literature could be found a case of apparent cure followed by a successful pregnancy. That this sequence of events is rare is by no means difficult to understand. In the first place, the mortality rate prevents such an occurrence. In those that survive, at least one ovary is removed surgically, and often the associated tube. In many, the other ovary is often the site of tumor formation also, or may have other disease present. The tubes, if not removed, may be distorted by disease and be obstructed. Some of the cases who were operated on early and survived, may have had postoperative radiation therapy which sterilized them.

It seems illogical to use x-ray therapy. If metastases have occurred, it does no good. If they have not occurred, the patient will recover without x-ray therapy. In our case, withholding radiation permitted her to lead a normal life, and fulfill all the duties of a normal woman. X-ray therapy would have gained us nothing, and produced a sterile, menopausal girl at 17, with a very dim outlook for future happiness in life.

SUMMARY

1. A brief review of teratoma of the ovary is presented.

2. A case is described where there was apparent surgical cure for over four years during which time the patient married and had a normal child.

3. X-ray therapy is ineffectual where metastases have occurred and is unnecessary and harmful where they have not occurred.

4. The only cure is early and complete surgical extirpation.

REFERENCES

1. Curtis, Arthur H.: Teratoma of the Ovary, Surg. Gynec. Obst. 81:504-506 (Nov.) 1945.

2. Bettinger, H. F.: Two Ovarian Teratomas, One Containing Cerebellar, The Other Cerebral Cortex. J. Path. & Bact., 53:284-286 (Sept.) 1941.

3. Smeltzer, Merrill: Solid Teratoma of the Ovary in the Young Girl. Am. J. of Obst. & Gynec. 41:616 (Apr.) 1941.

4. McElhinney, William T.: Solid Teratoma of the Ovary in a Fourteen Year Old Girl. Journal of Medicine 22:194-195 (July) 1941.

5. Neuhauser, H.: Teratoid Tumors of the Ovary. Asch. f. Gynök., 79:697, 1906.

6. Sturley, Rodney F.: Teratomatous Chorionephithelioma of the Ovary. Minnesota Medicine, 25:629 (Aug.) 1942.

7. Edmonds, H. W., and Hawkins, J. W.: Relationship of Twins, Teratomas and Ovarian Dermoids. Cancer Research 1:896-899 (Nov.) 1941.

8. Dreyfus, J. R.: Teratomas of the Ovary and the Endocrine Action of Tumors of the Ovary in Children. Arch. de Méd. d'enf. 39:721 (Nov.) 1936.

9. Pulskamp, M. H., & Griswold, R. A.: Secondary Intrarectal Solid Teratoma of the Ovary. Southern Surgeon 10: (Dec.) 1941.

DERMOID CYST OF THE BRIDGE OF THE NOSE

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THE rarity of reports in the American medical literature of cases of dermoid cysts of the dorsum of the nose probably does not coincide with the true incidence of this condition. Since almost all of the articles on this subject have appeared in the journals of otolaryngology, it seems likely that most general surgeons and practitioners who treat the majority of these patients initially do not appreciate the true nature of the deformity. This is borne out by the nature of the early treatment rendered many of these patients. Inasmuch as the successful treatment of this defect is dependent on the recognition of its development and the specific pathology involved, it appears advisable to add this report of an additional case, together with a brief review of the mechanism of its origin.

CASE REPORT

A male child 2 years old was seen with a complaint of swelling of the bridge of the nose for 3 days. He had had occasional discharge of a white cheesy material containing a few hairs from a sinus on the bridge of the nose which was noticed at birth. Swelling and redness of the bridge of the nose began for the first time 3 days previously and extended gradually to the adjacent forehead and periorbital regions. The patient had been previously well in every other respect.

Physical examination showed temperature 99.0°. The bridge of the nose was unusually broad and flat. Swelling and erythema of the adjacent forehead and soft tissues in the mesial aspect of each orbit was moderate. A pin-point opening was seen in the center of the bridge of the nose. A small amount of thick creamy fluid could be expressed from this opening. The heart was slightly enlarged with a regular sinus rhythm. A harsh systolic murmur, loudest over the mid-sternum and pulmonic areas, was heard over the precordium.

Urine examination on admission showed no abnormality. Red cell count was 4.68 million with hemoglobin of 81 per cent. White cell count was 7,800 with 41 per cent polymorphonuclears. Roentgen examination of the chest showed a configuratio of the heart which might be consistent with one more congenital anomalies. The skull showed symmetrical defect in the midline above the bridg of the nose which might be an incompletely close naso-frontal fontanel (Figure 1).

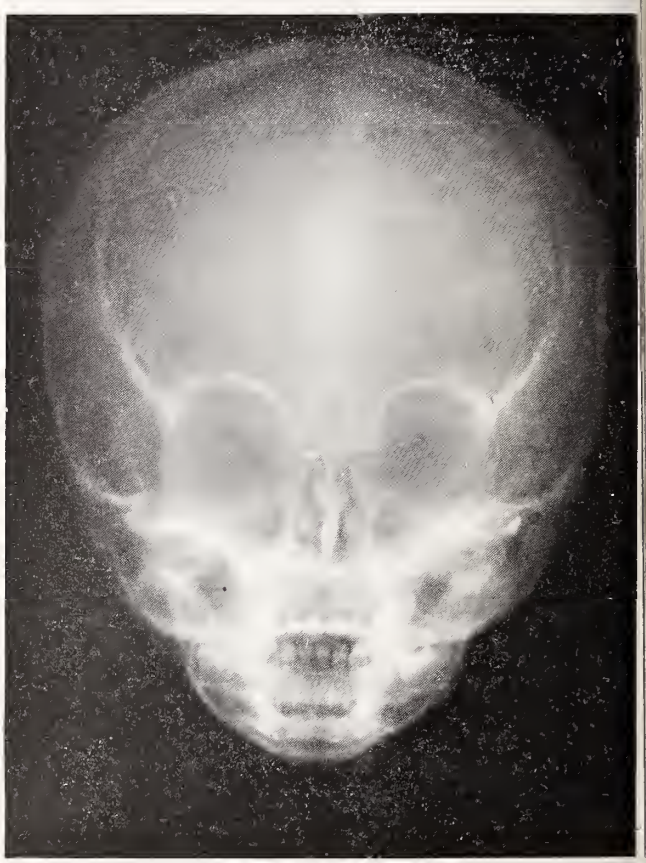


FIGURE 1

Roentgenogram of skull in postero-anterior projection showing a diamond-shaped defect in the midline above the nasal bones. No communication with the dura was demonstrated at operation.

The patient was treated with intermittent application of warm saline dressings to the affected part and intramuscular injection of 20,000 units of penicillin every 3 hours for 3 days. By that time, there was no evidence of inflammation and therapy was discontinued (Figure 2).

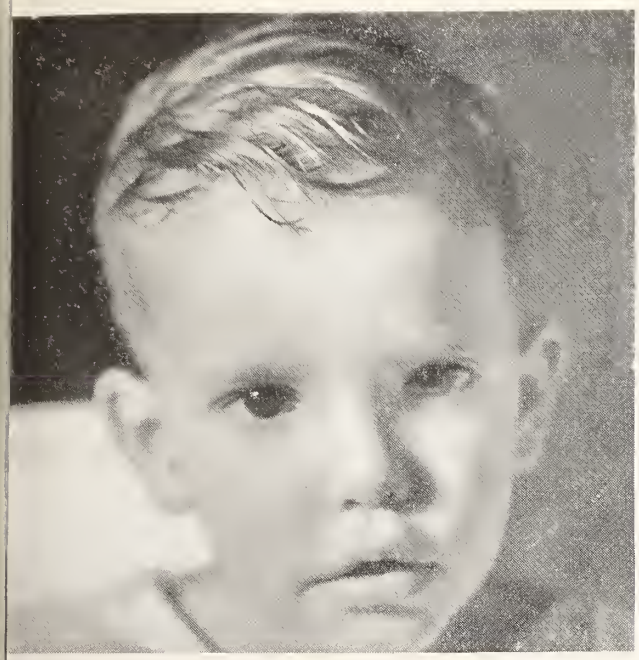


FIGURE 2
Patient before excision of dermoid cyst. Note the apparent broadening of the bridge at the nose. The sinus opening is barely visible.

On the seventh hospital day, excision of a dermoid yst from the bridge of the nose was carried out ith primary closure.

The specimen including the sinus tract measured 6 cm. in length after fixation (Figure 3). The sinus d in along a narrow trough in the nasal cartilage the body of the cyst which lay in a rounded epression of the cartilage beneath the nasal bones. hese bones were quite short and slightly separ-ed. Slight pressure on the cyst in the course of its moval resulted in the partial extrusion through its all of two small black hairs. When the cyst was pened, it contained a small amount of thick creamy aterial and a few hairs. Microscopic examination owed an epithelial lined sinus tract and a cyst wall ned by squamous epithelium containing hair fol-cles and small sebaceous glands.

Penicillin to the amount of 880,000 units was dministered just before and for 3 days following peration. All skin sutures were removed on the econd post-operative day and the wound continued o heal well. The child's appearance three months fter operation is shown in Figure 4.

IECHANISM OF ORIGIN

Gruenwald described in 1900 a theory of the echanism of origin of dermoid cyst on the bridge f the nose which has since been accepted by most



FIGURE 3
The dermoid cyst and its sinus tract removed at operation



FIGURE 4
Same patient three months after operation showing the midline scar

writers on the subject. His drawings were reproduced in 1942 by Brunner and Harned, who presented a review of the literature up to 1933 and added 2 cases of their own. Briefly, the nasal bones develop during the second and third month of embryonic life, after the cartilaginous capsule of the nose has already been formed. At this time, a small teat of dura mater which has been in close contact with skin begins to retreat through a small opening,

the foramen cecum, which is forming in the incisura ethmoidalis of the frontal bone. The naso-frontal fontanel closes and the nasal bones grow down between skin and nasal cartilage. If a portion of ectoderm remains adherent to the retreating dura, it is entrapped in this potential space between the nasal cartilage and the nasal bones, called by Gruenwald the pre-nasal space. A sinus to the skin may persist. This sinus may extend down the dorsum of the nose as far as the columella.

Dermoid cysts of the dorsum or septum of the nose may also be found in association with incomplete fusion of the nose. The mechanism of origin is here entirely different, but similar to that which results in the formation of dermoids at the other primitive facial clefts and elsewhere in the midline of the body. New and Erich reported on 103 dermoids of the head and neck seen at the Mayo Clinic of which only 13 were of the dorsum of the nose and 9 of those on the bridge. This discussion will be limited as far as possible to those cysts which have their origin primarily at the latter point.

PREVIOUS REPORTS

The forty-three titles listed in the bibliography of this paper do not represent all the references to this subject in the literature. They do include all the reports of cases which could be found, however, and those writings which were most important in developing the present concept of origin of this anomaly. Since the descriptions of many of the cases mentioned are fragmentary, and since many of the earlier and some of the later writers have not made the differentiation between cysts arising in the septum and on the dorsum of the nose, it is impossible to say exactly that every one of the 81 patients mentioned belongs in the latter group. Careful consideration of the discussions included in these reports makes it seem likely that all but a very few do fall under this classification, and that the others may well do so. This, then, is the most complete collection of these cases yet compiled. Brunner and Harned in their review published in 1942 could find only 28 cases, including 2 of their own.

The earliest case recorded is that of a 15 year old girl operated on by Dieffenbach and reported, according to Bramann, in 1829. The first case in the English literature is one which Lawrence reported in 1838 as cured following excision of the tumor. In this country, the first report in 1900 comprised 3 cases seen by Birkett, of which 2 were subjected to operation.

In 48 of the total of 81 cases the sex of the patie was given. Thirty-two were male and 16 fema It is interesting that the observed sex incidence a much more common dermoid cyst, namely t pilonidal cyst, shows a male predominance.

In 43 cases, the age of the patient was given. T youngest observed was, of course, in a newbo and the oldest in a patient of 58, who, incidentall refused treatment. The following table shows t age distribution by groups.

TABLE 1

AGE GROUP	NUMBER OF CA
Less than 1 year	4
1–5 years	10
6–10 years	5
11–15 years	3
16–20 years	8
21–25 years	7
Over 25 years	6

It would be expected that a large number of cas would be brought for medical treatment betwe the ages of one and five. During this period, t persistence of a fistula which has been present sin birth, the progression in size of the tumor or superimposed infection may call attention to t anomaly. It is surprising, however, that so man patients between the ages of 16 and 25 are seen f the first time by surgeons. Several factors are r sponsible for the delay. Some of these cases have n had a fistula and there has been no sudden increa in the size of the small tumor which was present birth. Others are brought to light following traum to the nose which is frequent in this period, pa ticularly in males. Still others have had inadequat treatment by someone who failed to recognize th true character of the defect and these are sufferin from a recurrence. Finally, there are some wh have had a noticeable lesion for some time but i whom the cosmetic effect did not seem importan until they reached the age of courtship.

In 62 cases where the presenting site of the tumo mass or fistula was specifically indicated, it occurre on the bridge in 36, along the remainder of th dorsum in 17, and at the tip in 9. From the lowe sites, the tumor could be traced up to its source jus below or behind the nasal bones in most instance In about half the cases where the presence or ab sence of a fistula was noted, one was present.

The influence of heredity in this deformity doe not appear to be outstanding, but Stupka reports case of a father and daughter, and New and Erich

a mother and daughter with dermoid cyst of the idge of the nose. Furniss treated twin boys aged e with the same lesion.

There is unanimous agreement in the literature as the only effective treatment of this condition. o successes are reported where there has not been complete excision of sinus, if present, and the mplete cyst. Several instances of recurrences after tempted excisions are mentioned. Simple drainage ith or without cauterization has not been success- l in any reported case. While a scar in a very ominent place results, the deformity is very little mpared to the results of inadequate treatment ith repeated infection, soft tissue swelling, and e formation of multiple sinuses.

MMARY AND CONCLUSIONS

(1) A case of dermoid cyst in a 2-year-old male ild, treated by primary excision is reported.

(2) The mechanism of origin of dermoid cyst on e bridge of the nose is discussed from the stand- int of the developmental anatomy peculiar to that rticular region.

(3) 81 cases of dermoid cyst on the dorsum of e nose are collected from the literature and a ibliography given.

(4) There is an apparent predominance of this eformity in males by a ratio of 2:1.

(5) Although this is a congenital defect, many atients do not come to surgeons for treatment until ey approach maturity.

(6) There is some evidence to indicate a possible ereditary factor.

(7) The only successful treatments reported have een by complete excision of the cyst and the ccompanying fistula.

BIBLIOGRAPHY

. Benjamins, C. E.: Acta Otolaryng., 24-284, 1936.
. Birkett, H. S.: Tr. Am. Laryng. Ass., p 97, 1900 N. Y. Med. Jour., 73:91, 1901.
. Bland-Sutton, J.: Practitioner, 59:463, 1897.
4. Blegvud, N.; Zbl. f. Hals, Nas. u. Ohrenh. 15:57, 1930.
5. Bramann, F.: Arch. f. Klin Chir, 40:101, 1890
6. Brunner, H. and Harned, J. W.: Arch. Otolaryng. 36: 86-94, July 1942.
7. Bruzzone: Atti. d. XVIII Cong. Soc. ital. d. otol., rin., e laryng., p. 76, 1922.
8. Cambrelin: Arc. Int. de. Lar., 36:1121, 1930.
9. Citelli: Atti. d. XI Cong. Soc. ital. d. otol., rin., e laryng., p. 153, 1907.
10. De Buch: Flandra M. J. 8:65, 1893.
11. De Carli: Arch. ital. d. otol., 14:455, 1902.
12. Dieffenbach: 1829. Quoted by Bramann.
13. Esau: Fortschr. a.d. Geb. d. Ront., 31:262-263, 1923.
14. Evans, J. H.: Brit. Jour Child Dis, 8:535-539, 1911
15. Fehleisen: Deut. Ztschr. f. Chir., 14:5, 1881.
16. Furniss, F. W.: J. Laryng. and Otol., 53:314, 1938.
17. Gruenwald, L.: Ztschr. f. Ohrenh., 60:270, 1910
18. Hagens, E. W.: Arch. Otolaryng, 28:399-403, Sept. 1938.
19. Hart, V. K.: Laryngoscope, 37:760-763, 1927.
20. Hebert: These de Bordeaux, 1912.
21. Holmes, E. M. Ann. Otol., Rhin., and Laryng., 51:662, Sept. 1942.
22. Johnson, R.: Tr. Clin. Soc. Lond., 37:227, 1904.
23. Juers, A. L. Arch. Otolarnyg., 33:851-852, May, 1941.
24. Kharchak, E.: Acta Otolaryng., 19:73-76, 1934.
25. Lawrence, W.: Lond., Med. Gaz., 21:471, 1838.
26. Luongo, R. A.: Arch. Otolaryng., 17-755-759, June 1933.
27. Malbec, E. R.: Semana Med., 2:188-192, Sept. 30, 1943.
28. Marchini, F.: Policlinico (Sez. Prat.), 30:1422, Oct. 1923.
29. Nager, F. R.: Monatschr. f. Ohrenh., 66:60, 1932.
30. New, G. B. and Erich, J. B.: Surg., Gyn. & Obs., 65:48, 1937.
31. Parkinson, S. N.: Arch. Otolaryng., 34:829-831, Oct. 1941.
32. Porto: Rev. Otolaryng. de San Paulo, 5:275, 1937.
33. Powell: Arch. Otolaryng., 19:67, 1934.
34. Rosedale, R. S.: Ohio St. M. J. 38:132-134, Feb. 1942.
35. Simonetta, B.: Bol. d. mal Orecchio d Gola ed Naso, 57:503, 1933.
36. Streit, H.: Arch. f. Laryng. u. Rhin., 24:454, 1911.
37. Stupka, W.: Die Missbildungen der Nase and des Nasenrachenraumes, Berlin, Julius Springer, 1938.
38. Titche, L. L. and Glasser, G.: Med. Bull. Vet. Admin. 21:92-94, 1944.
39. Trampenau: Ztschr. f. Hals. Nas., u. Ohrenh. 28:163, 1931. Rev. d. Laryng. et d'Otol. 53:412, 1932.
40. Vermeulen, B. S.: Acta Otolaryng., 16:48-56, 1931.
41. Waldapfel: Arch. Int. d. Laryng., 35:358, 1929.
42. Wiskowski: Arch. Int. d. Laryng., 34:1092, 1928.
43. Yearsley, M.: Brit. Jour. Child. Dis., 9:160-161, 1912.

LOCAL PUBLIC HEALTH PRACTICE IN CONNECTICUT TODAY

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Since 1911, when the first full time county public health unit was established in the United States, state departments of health have been busy at work to make the services of a modern public health program available in all communities of the country. From 1911 up to 1935, progress was discouragingly slow. However, a new and potent force began operating with the passage of the Social Security Act in 1935. This act gave further impetus to efforts to expand full time health services by providing states with grant-in-aid funds to augment the meager personnel in state departments of health, and also by providing financial assistance to local communities in establishing local departments of health, staffed by adequately trained personnel and devoting full time to their work.

In addition, these funds were available to give formal training in public health to personnel already employed in official health agencies. With a view to encouraging states to expend more for health protection of their residents, the federal law required that a certain portion of the allotment be matched with state funds.

With this added stimulus, the period from 1935 to just prior to World War II saw the number of local full time public health units increase from 762 to approximately 2,000. But it soon was apparent that these rapid strides were not sufficient. A survey in 1942 made by the committee on administrative practice of the American Public Health Asociation, of which Haven Emerson, M.D., is chairman, revealed that approximately one-third of the country's entire population still does not enjoy the important services provided by a modern public health program. This is surprising in our land of plenty where, for some time, we have recognized the importance of personal health and its effect on the acquisition of education by our school popul tion.

Early public health practice concerned itse chiefly with the control of widespread epidemi and environmental sanitation. Through the consta vigilance of state departments of health and th appliance of effective immunization agents, suc widespread epidemics are now a thing of the pas Too, continuous work in the field of environment sanitation was largely responsible for drastically lowering the number of cases and deaths from th diseases of intestinal origin. Much of this was accon plished before the modern science of bacteriolog was developed. Since the specific causes of disea were not known, the important role which th individual has in a disease control program was n considered.

No doubt this situation was, in no small measur responsible for much of the complacency of man communities. They thought, and many still thin that a public health program does nothing more tha engage the services of practicing physicians an nurses whenever a community is threatened by disease outbreak.

To the trained and experienced observer th concept is quite remote from the truth. With th development of the modern science of bacteriolog and the advances achieved in medical and publi health practice, we now know that each individu has an important responsibility in attaining vigoro personal health and in protecting the health of h neighbors, and thus has a stake in the health statu of his community. We know the specific causes many diseases and how communicable diseases a spread. With the emphasis shifting to the individua it becomes quite apparent that there is need for continuous program for the dissemination of th knowledge at hand in order that people may prof by its use.

In addition to this shift of emphasis, our prese concept of public health practice has broadene

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onsiderably. While communicable disease control nd environmental sanitation are still important hases of the modern public health program we ust also include such other activities as vital statis- cs, maternal, infant, preschool and school health, ental hygiene, mental hygiene, chronic disease, etc. erhaps one of the most important services is that f community organization for health education. ur experience has taught us that regardless of the cilities available, the public will not use them until ey are convinced of the importance and need of commendations made by the local department of ealth.

With this background of information, let us now onsider local public health practice in Connecticut day. It should not be too surprising to a rural roup to learn that Connecticut does not compare vorably with the rest of the country with only 50 er cent of the population of the state served by 13 ll time local departments of health. These units re located in our larger cities and towns and cover ss than 10 per cent of the geographic area of our ate. Six of the 13 were established since 1935.

The other half of the population, primarily rural, served by part time health officers. Since these en derive their livelihood from the private practice f medicine, and the local appropriations for public ealth work are inadequate, it is obvious that time ill permit caring for only emergency services in e field of communicable disease control and en- ironmental sanitation. Our part time health officers ave realized for some time that they are unable to ope with the needs of their respective commu- ities. When the war emergency was over they oted unanimously a resolution at the fall health fficer's meeting in 1946 supporting the plan of full ime local health districts, staffed by trained and xperienced personnel. The House of Delegates of ur State Medical Society took similar action. Public Health has now assumed its place as a true specialty.

In addition to the practicing physician serving art time, there are many agencies engaged in ealth activities in towns throughout the state. The rivate public health nursing and visiting nurses ssociations started primarily for the bed-side care f the sick, but gradually expanded their programs, s personnel permitted, to do preventive work and ealth education. They have done such good work hat many towns feel that if they have a public ealth nurse in the area there is no need for a health epartment.

Local boards of education also employ physicians and nurses to conduct the school health program. In most instances the work done falls far short of what is today considered a good school health program.

Such non official agencies as the local tuberculosis society, the cancer society, the infantile paralysis committee, the mental hygiene committee and others are busy also with specialized programs.

Each of these local agencies, working more or less independently, thinks that their combined efforts adequately supply the communities needs. However, on careful examination it becomes clear that there are many and serious gaps in a program of this sort.

The state department of health, to the limit of its staff and facilities, has attempted to make up these deficiencies. But it is neither desirable nor could it ever be expected that the budget of the department be increased to adequately meet the public health needs of the 169 towns of the state.

With the responsibilities for local public health thus divided between so many agencies, it is quite apparent from our principles of good administration that inefficiency, duplication of effort and even frustration must result; this in a time when professionally trained personnel is at a premium. There is need for some one familiar with the overall program to serve as coordinator. The health officer has the legal responsibility for the public health program; lack of training and insufficient appropriations limit his activities.

Connecticut provides a setting which would make it possible to develop local public health programs that might well serve as a model for the country.

The area of the state is small and with good roads, it is possible for state consultants to answer calls within a few hours after they are received. In some of the larger states where personnel is limited, the philosophy of "Time Heals Everything" seems to be in practice.

Our high per capita income makes it easier for communities to meet their share of the costs of these public health services.

The ratio of physicians, dentists and nurses per unit of population compares quite favorably with many areas of the country. Furthermore, a good hospital is within 25 miles of every resident of the state. The present average of 3.99 beds per 1,000 population is considerably higher than the national average. Under the Hospital Survey and Construction Act, Public Law 725, there are prospects that

this average may be increased to better than 5 beds per 1,000 population within the next five years.

Under the law, funds are available to assist communities in building public health centers to properly house local health units.

Connecticut does considerably better than many states with its appropriations for public health.

Since 1917, our state has had permissive legislation which allows the more sparsely populated towns to pool their resources and establish district departments of health for efficiency and economy. Recently, the 1947 General Assembly amended this law to provide state financial assistance for the project. While the appropriation is a modest one, $25,000 for the biennium 1947-49, it is reasonable to assume that if sufficient towns express their willingness to establish such a district department of health by a town vote before the next general assembly, this appropriation will be increased to take care of the wishes of the people of the state.

It is always important to give consideration to the financing of any new undertaking. Last year, 83 cents per capita was spent from local tax funds fo public health protection. It has been estimated tha from $1 to $2.50 per capita would provide full tim public health services, depending upon how com prehensive a program is desired.

If towns pooled their resources and formed district many towns would spend considerably les than they are expending now for part time pro grams. This is because the state would share 50 pe cent of the cost as long as the funds hold out. Suel assistance may not exceed $4,000 for any one tow and not more than $20,000 for any one district regardless of the number of towns forming th district.

To attain the goal of full time public health serv ices for all residents of Connecticut, your coopera tion is necessary. Organize your communities an acquaint them with the plans and then see that a your next town meeting a resolution is passed t join a local district department of health. Only wit local public health machinery is it possible to im prove rural health in Connecticut.

NEW HORIZONS FOR OLD AGE

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A CENTURY and a half ago, Horace Walpole wrote these lines: "About the time, or a little later, I die, the secret will be found of how to live forever." Feeling that enough time had passed to vouchsafe a reply, Helen Bevington answered:

"Horace, be comforted to die.
One century has meandered by
An half the next since, it was true,
The temporal state eluded you.
Now as I read your pensive letter,
I wish myself that times were better
And I might boast how men contrive,
As you foretold, to stay alive.
By now we should possess the key
To fleshly immortality
And, if we wanted to, endeavor
To live forever and forever.
This, to my infinite regret,
Is not a custom with us yet.
I write you Horace for good cheer
Life is about as usual here."

Unfortunately, life is about as usual here so far as our knowledge of the nature of the ageing process is concerned.

In a sense we are now standing where the stream divides. For generations we have followed the branch of infectious diseases. It has dwindled in size, but we have not yet really started the exploration of that other stream that flows in the direction of the chronic diseases of adult life and geriatrics. In the past our chief endeavor was to learn to run the gauntlet of infections so that we might be able to raise a reasonable number of our children to adult life. But as a result of our success in conquering in-

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ctions and some of the most deadly diseases of nildhood, we now have an adult population that is rger in proportion than it has ever been before. promises to grow even greater as the years roll y. This poses new public health problems, and itherto neglected diseases assume compelling im- ortance. A whole new field of knowledge is wait- ig to be studied and mastered. We haven't even egun to think seriously about the medical and ociological problems of old age. Neither medicine, or industry, nor the State, has any carefully nought out program of what to do about the vast opulation of older persons that is rising in our idst. Only Dr. Townsend has a $50 every Friday lan which most doctors feel is not the answer. But ne care of the aged must not be left to the old man ith the long white beard and the scythe.

Our research has not scratched the surface of such onditions as heart disease and coronary thrombosis, poplexy, nephritis, arthritis, and cancer which are nly a few of the cheerful prospects of advancing ears. We know more about the planet Mars than e know about the pathogenesis of arteriosclerosis hich is probably the least common denominator f most of the disabilities of the ageing process.

Some indication of the increasing importance of ne problems to which I have alluded may be gained rom figures on the percentage of our population in ne older age groups. According to U. S. Census gures, and reliable estimates with respect to the uture, the proportion of our population 45 years of ge and over appears as follows. These figures do ot take into account the possibility of future ramatic medical discoveries that might further hange the longevity picture.

1860—13.1%	1940—26.5%
1880—16%	1960—33.3%
1900—17.8%	1980—40.3%
1920—20.8%	

When we consider those 65 years and over, the ollowing percentage distribution is reflected:

1860—2.7%	1940— 6.8%
1880—3.4%	1960—10.0%
1900—4.1%	1980—14.4%
1920—4.7%	

The important facts to be derived from these data re that the weight of our population is shifting oward the older group and by 1980 two-fifths of ur population will be over 45, and one-seventh over 5. At the same time the total number of our people is also increasing. It has been conservatively estimated that we will have not less than 150 million people by 1980. This means that by that time there will be not less than 60 million 45 years and over and over 21 million 65 and over. Think of it, 21 million persons 65 and over! These figures have special significance in the light of the all time employment record of almost 60 million gainfully employed which has just been attained and this means that in less than 33 years we shall have more individuals over 45 years of age than the total number employed at the present time. We must also anticipate the continued introduction of new labor saving devices perhaps on a scale never dreamed of before. The technologies recently developed, particularly in electronics and the upswing of interest in science generally should provide for that. If we do nothing about it and maintain present day working standards and conditions we shall have a potential labor surplus of over 30 million workers by 1980.

What to do about the aged and the partially disabled? We can't plow them under as we used to plow under corn, potatoes, tobacco, and little pigs in accord with Henry Wallace's advice. And I am equally certain that we can't just turn them out to pasture and expect them to enjoy life. People are not happy when they are idle and this is particularly true of older individuals. Youth can loaf content with opiate dreams of future achievements. But as we grow older the realities of life are more clearly seen and less easily denied and as we approach 50 and 60 we can no longer derive solace from the pipe dreams of future achievements. Similarly the diversion of participation in sport and exercise are denied us. Age plays for real stakes not pastime. It wants something to do and it must be real. And the most real thing we have to sustain us in this life of ours is useful work. Have you seen, as I have, a faithful employee who has been working at his job for 20, 30, or 40 years and wants to continue? Have you seen such an employee "retired" to the boneyard by some blind compulsory retirement scheme. There is an unutterable sadness about it that sometimes makes me think that it would be kinder to shoot the old fellow. I believe I understand why so often they die shortly after retirement. For any biological organism that has been accustomed to a set routine for 40 or 50 years can't suddenly be shaken from its orbit without untoward consequences. Anyone who has studied Cannon's ideas on homeostasis will recognize this.

In considering the problems of longevity we might ask ourselves, "When are we old?" To a child of 7, an adult seems ancient at 30. According to a Frenchman forty is the old age of youth, and fifty the youth of old age. Most people as they grow older cling to life with a desperate grasp, thrusting the period of old age ahead of themselves so that they always view it as something older than the years they have lived—like the geometrical definition of parallel lines that never converge. For those that are very young old age is marked as beginning with the period when the hair turns gray, shoulders stoop, the skin loses its smoothness and physical agility, speed, and endurance has perceptibly declined. Sometimes it is not these things that are as annoying as some of the more exquisite aspects of growing old, as reflected in the following lines:

SO THIS IS MIDDLE AGE!

It's not the thickened midriff that I mind,
The shortened breath which says three sets of doubles
Will be enough (it is enough I find);
Shortcomings yes, but oh, such minor troubles
Compared with youth's smug deference polite
Which types one as a hoary oracle
To answer questions deep into the night
About events which youth regards historical.
You'd think that Coy or Brickley or Mahan
Were Hannibal, Ulysses, or Balboa;
While Dempsey, Tunney, and that Firpo man
Had boxed the compass with old skipper Noah;
The feline Lenglen and the pig-tailed Wills,
Whom only yesterday I saw do battle,
To youth, alas, seem older than the hills—
Skeletons the youngsters love to rattle.
Remind me, kids, when next you stop for tea,
I'll tell you what I heard Grant say to Lee!

From a strictly scientific point of view the ageing process begins at conception. The very instant that cells, tissues or organs stop growing they begin to decline. This decline marks the beginning of old age. It starts slowly but it begins early in life. The The thing popularly called old age is in truth only that period in which the rate of decline has become accelerated and the manifestations so gross that they are visible to the naked eye. It is true that different races of man and different species of animals decline at varying rates. What the responsible factors are we really don't know despite the following intriguing suggestion:

The horse and mule live thirty years,
And nothing know of wine or beers.
The goat and sheep at twenty die
And never taste of Scotch or Rye.
The cow drinks water by the ton,
And at eighteen is mostly done.
The dog at fifteen cashes in
Without the aid of rum or gin.
The cat in milk and water soaks
And after twelve short years it croaks—
The modest, sober, bone-dry hen
Lays eggs for nogs, then dies at ten.
All animals are strictly dry;
They sinless live and early die.
But sinful, ginful, rum-soaked men
Survive for three score years and ten.
And some of us, though mighty few,
Stay pickled 'til we're 92!'

Our Society has been quite illogical and inconsistent in its attitude toward the older worker. On the one hand it is apparent that we have no objection to electing and appointing older individuals to positions of the greatest responsibility in government business, and the professions.

For instance, in the 79th Congress 32 Senators or 41.3 per cent were over 65 years of age, 12 or 15.5 per cent 61 to 65 years of age, in other words, over 56 per cent were over 60. In the House of Representatives, 57 or 21.3 per cent were over 65 years of age, and 36 representatives or 13.4 per cent were 61 to 65 years of age. A study was made of top business executives as listed in Poor's Directory. Taking 500 consecutive names contained theren it was found that 143 or 28.6 per cent of those listed were over 65 years of age, 78 or 15.6 per cent were between 61 and 65 years inclusively. Here again, over 44 per cent are over 60 years of age. I am certain that a study of the leadership of the various professions would reveal the same large proportion of individuals in the older group.

And yet as far as the rank and file of workers is concerned we have no objection to the imposition of blind, and unselective compulsory retirement rules which automatically eliminate those in the ranks who have reached the same age regardless of their fitness, ability, and contribution to the group for which they labor. More precious than oil or fertile soil, than ore and minerals, than trees or an equable climate, are the human resources of a country. All other things were here when Columbus came to America, but it took intelligent, industrious men to make our country what it is today. We may not fully realize it, but we cannot afford to waste the contributions of those who through years of experience have learned to do their jobs well and are willing and able to continue to do so faithfully.

raining and experience can only be replaced by raining and experience and when we retire a competent older worker his successor has the burden, nevitably, of supporting him as well as himself. ome individuals welcome retirement and the possibility of voluntary retirement on a pension should lways remain open for these. But, if the premise is hat all individuals over 65 or 70 are not worth their eep then least of all should we permit individuals bove those ages to occupy the top and critical ositions in our social structure. If we acknowledge, s is certainly true, that some are and some aren't t and pulling their weight at those ages, then we hould use our intelligence to devise methods of etermining which are and which aren't fit for all orkers, not just the upper crust. As the great hysiologist, A. J. Carlson stated, "The physiologic ge of the worker is not synonymous with his hronologic age, owing to the individual variables n heredity, mode of living, accidents and sequelae f disease." Likewise, "All age changes come on radually" according to Carlson, and we know now hat in some individuals changes characteristic of enescence begin even in childhood. And biologically we all start to grow old the moment we stop rowing. That such changes may proceed very radually and slowly is illustrated by the fascinating nd possibly authentic story of Christen Jacobsen Dragenberg reported in the *Journal of the Institute f Actuaries*. Dragenberg was a Dane who lived to e 146 years of age from 1626 to 1772. He went to ea when he was 13, took part in the wars of three ings against Sweden, served many nations in merhant navies, when nearly 70 was taken prisoner by Algerian pirates, was sold as a slave, escaped slavery fter fifteen years, and at 84 again went to war gainst Sweden. At 111 he married a woman of 60, utlived her, proposed at 130 to several women but was rejected. Mastering his disappointment, he lived n for sixteen years. Described as being of impetuus temperament, he lived a life far from blameless, ut in his last five years, from 141 to 146, exhibited conduct "quite respectable." If one man can live life as full as this there is no reason why science annot make it possible eventually for many more f us to marry at 111, propose and *be accepted* at 30, and live to 146.

We choose and select when we hire, and I see no eason why we can't do the same thing when we etire our workers. In 1930 on the basis of a compulsory retirement rule, the most distinguished neurological surgeon the world has yet known, Harvey Cushing, was retired from the Harvard faculty at a time when he had useful years ahead of him. He promptly accepted a full time academic appointment at Yale where he continued his outstanding contributions to medical science. What was Harvard's loss was Yale's gain, but for Dr. Cushing the retirement rule meant only the waste of time and inconvenience of pulling up stakes, moving, and finding a new home. One of the best teachers it has been my privilege to know and an outstanding figure in Public Health work, Dr. Milton J. Rosenau, was retired from the same faculty. He too moved to another University where the rules were not so blind. He continued his contributions to public health, which could be duplicated by very few in the world, and was subsequently elected President of the American Public Health Association. The story is told that as he lay on his death bed last year, he cocked open one eye as he had a habit of doing, saw the pretty nurse standing before him and spoke his last words: "I feel I am taking a turn for the nurse." From a sociological standpoint inflexible chronological retirement rules are ridiculous, and a reflection on the state of our intelligence in solving what ought to be a simple problem. Whenever society adopts a rule that eliminates the fit with the unfit, destroys the good with the bad, or punishes the innocent with the wicked, it is not a good rule. Society progresses by changing rules of this kind. In an imperfect society human beings are pushed around as a faceless mob. But social progress may be measured in the last analysis by the degree of skill and discrimination with which society solves the individual problems of its members.

The argument has been advanced that we must clear out the older workers to make room for the younger men so that their progress upward in an organization will not be unduly stymied. On the face of it this line of reasoning appears to have some merit. But it is only another way of stating that there are more workers than there are jobs. During the war when there was a manpower shortage, no one was afraid that the old, the lame, the blind, and the halt, were taking jobs away from younger and more able workers. At other times similar arguments have been applied against the employment of women in business, government, and the professions. Certainly there is no arbitrary age at which older workers begin to repress the advance-

ment of younger individuals. In a sense, every older individual higher on the ladder of advancement, whether he be 65 or 55 or 45 is holding a job that a younger individual aspires to and feels he can fill. That is always true and it will be just as true if we force everyone to retire at 50 or even 45 as we will have to do by 1980 if we don't find a more logical way of reducing the disparity betwen jobs and workers. We must not lose sight of the fact that someone must support those that we retire to idleness. The more workers we retire and particularly if we should lower the retirement ages, the greater will be the economic burden we will place on those who work. They will have to produce enough to support themselves and their families as well as the increased numbers of those who become emeritus workers. The whole problem is the adjustment of the number of workers to the number of jobs available. To attempt to strike a balance by eliminating all workers over a certain age is an unfair penalty on age and experience. In a refined and delicate way it is a perpetuation of the jungle law of the fang and claw where the leaders of the pack survive only until the younger beasts grow fierce enough to eliminate them. In modern civilization we are less violent but the end result is approximately the same.

One of the most important steps in solving this problem is the successive reduction in working hours for all workers rather than by reducing more and more older workers to a state of parasitism. I venture to say that you and I will live to see a thirty hour week in industry.

Another view that is widely held is that older individuals become over-conservative, and to make progress we must eliminate these obstacles in the path of progress. Here again there are such wide variations in human reaction patterns that I don't see how one can logically draw generalizations that will fit individual cases. Certainly Bernard Baruch, 77 years of age, Serge Koussevitsky age 73, Arturo Toscanini age 80, Herbert Hoover at 73 and Nicholas Murray Butler at 85 are no obstacles in the path of progress, and neither Senator Pepper, Henry Wallace, nor Tommy Manville have become more conservative as they have grown older. As far as the great mass of jobs now subject to compulsory retirement are concerned, it makes no difference at all whether an individual grows more or less conservative. If individuals in key positions become too conservative with age or even too reckless as they sometimes do, to meet the best interests of the organization, a retirement board operati on a selective basis can function to correct th development, as well as any others that may arise.

During the past decade industry and our Feder and State Governments have made great advane in provisions for the care of the aged. What w have accomplished is only a start and much mo remains to be done. I am hopeful that the maj burden of this can be carried by the extension voluntary retirement plans in which the employ and the employee share the cost. Not only mu more realistic retirement benefits be provided, b such plans must be more widely adopted by en ployers generally. The problem of transferring r tirement benefits without loss when an employe moves from one job to another remains to be solve Under present day practices a worker who chang from one job to another to advance himself, or f any other reason, is penalized by loss of the portio of his retirement accumulation which the employe contributes. For those not covered by adequa voluntary retirement programs, the present toke social security benefits must be increased, and ol age assistance on a lower scale provided for thos who, for one reason or another, have failed to ear their share of the retirement burden.

Through workers' compensation and health ace dent and disability insurance we have also take important steps in caring for those who are chronic ally ill and partially or totally disabled. Here agai we have only made a start. There is room for in provement not only in the provisions made for th economic care of these unfortunates, but also in th medical and institutional care made available. W can understand why general hospitals wish to avoi having their beds filled with "chronics," but we wi need an ever increasing number of institutions d voted solely to these cases.

While social advances in the direction I have ind cated will cost money, there is no contribution w can make to human welfare and happiness that is greater fundamental importance. Compared wit the tax burden of war and armaments, which huma ingenuity should be capable of eliminating, it negligible. Even this tax burden can be lessened b permitting capable and willing older workers t continue working, and finding more places in indus try and government for those partially disabled. I we will employ one-third of the 21 million over 6 years of age which we will have by 1980, at let say an average of $2,500 per annum, it will mean

llion 500 million dollars per year ($17,500,000,-o) that they will earn for themselves and which ld of support will largely be taken off the should-s of other younger workers, whether by taxes or rect contributions.

As we progress to a more perfect civilization, the al of which is nothing more than a greater meas-e of happiness for all mankind, there is much that mains to be done for those that are aged and ronically ill. The following general principles ll, in my opinion, serve as a guide toward this end:

1. Since physiological age is not synonymous with ronological age, compulsory retirement on a cal-dar age basis should be abandoned.

2. Since hiring is selective and based on fitness to a given job, retirement should likewise be selec-e and based on unfitness. If we can do one there no reason why we can't do the other.

3. Compulsory retirement should be based on the commendation of a retirement board composed of edical and psychiatric members as well as admin-rative officials.

4. In accord with Carlson's idea, if wage in pro-rtion to performance is recognized as a funda-ental principle, the older worker should taper off industry, just as the young apprentice gradually orks himself up in skill, performance and remuner-ion. In other words opportunities for down ading in position and salary should be offered. If is becomes a general practice, the aura of foolish ide which now stands in the way of this would on disappear. The older worker can choose re-ement if he doesn't like the idea.

5. Industry, governmental and private institutions ust make a greater and more intelligent effort to employ partially disabled persons.

6. When the aged and disabled have work to do they are less of a burden, financially, socially, and spiritually to the folks at home. Other things being equal home environment is better than an institution for the aged and disabled and the strong and fit must learn to exercise a greater measure of patience, tolerance and kindness toward them.

7. Institutions for the aged and disabled must be changed from asylums to modern institutions where every convenience and scientific development is available for their physical, mental and spiritual comfort. The importance of occupational therapy must not be forgotten. Useless work such as basket weaving is not the answer. Under ideal conditions each institutionalized person will have a job tailored to fit his ability and aptitude and for which he will be paid in proportion to his production.

This paper has only one purpose: To emphasize the growing importance of the problem of the aged and chronically ill. It is a plea for the devotion of more thought, more research, and more funds to improve the lot of the largest and most neglected group of unfortunates in our society. It is from those interested in public health and welfare that we may expect leadership in this endeavor.

Old age is not a disease but the disabilities arising from it are. As we overcome these we not only postpone old age but we defeat the suffering and sorrow that comes with it. Death has its final victory but it can come in peace. But in the meantime I like Llewelyn Powy's philosophy: "We sail in leaky bottoms and on great and perilous waters. Old and young we are on our last cruise. If there is a fill of tobacco among the crew, for God's sake pass it around, and let us have a pipe before we go!"

AN EVALUATION OF THE USE OF STREPTOMYCIN IN TUBERCULOSIS

The Medical Advisory Committee of the Connecticut State Tuberculosis Commissior

As soon as streptomycin was made available for general use (January 1947), the State Tuberculosis Commission began its program of treatment using this antibiotic. The following evaluation of its use, based on the experience at the sanatoria and elsewhere, has been drawn up as a suggested guide in the use of this preparation in the State Sanatoria. Preliminary studies with streptomycin by this group preceded the general program by many months. Thus far (January 1, 1947—December 1, 1947) in this general program, streptomycin has been used in the treatment of 171 patients with various types of tuberculosis, pulmonary and extra pulmonary.

The true value of streptomycin in the treatment of tuberculosis, its dosage, indications and contraindications, toxic manifestations and end results are still in need of prolonged study. In view of our limited knowledge, streptomycin should be used in carefully selected cases only and the patient should be under close hospital supervision during treatment.

I. ADMINISTRATION OF THE STATE TUBERCULOSIS COMMISSION PROGRAM

In order to provide for the purchase of streptomycin for treatment of patients at State Sanatoria, a special fund has been set aside for each of the fiscal years 1947-48 and 1948-49.

Any person admitted to one of the State Tuberculosis Sanatoria is eligible for streptomycin therapy from this state fund without additional cost to the patient, if medical approval is granted by the Medical Advisory Committee. This Committee, composed of the superintendents, the assistant superintendents, the chief surgeon, the director of the Central Laboratory of Pathology and the director and assistant director of Tuberculosis Control, passes on all cases for streptomycin therapy requiring the use of state funds.

A patient is first considered as to suitability for streptomycin therapy by the medical staff of the sanatorium at which he is a patient. If the staff approves the use of streptomycin, an historical summary and representative x-ray films are sent to the Medical Advisory Committee via the Commission Office at 119 Ann Street, Hartford, Conn.

A patient on the admission waiting list, considered suitable for streptomycin therapy by outside medical authorities, may also have a summary and representative films submitted to the Medical Advisory Committee via the Commission office. In this manner, if streptomycin has been started on the outside, it is possible to continue it without interruption upon transfer to a State Sanatorium, provided approval of the Medical Advisory Committee is obtained while the patient is on the waiting list. Streptomycin will *not* be supplied from this state fund until the patient is admitted to a State Sanatorium.

Each case is submitted to the Medical Advisory Board members for their individual judgment and the majority opinion is accepted. Letters are then written from the Commission office stating the decision reached, the films are returned and the summary is filed in the Commission office. An amount of streptomycin sufficient for the course of treatment is delivered to the sanatorium on approved cases.

The following form illustrates the type of information desired in the medical summary:

Case Register Number..... Date.....

REQUEST FOR STREPTOMYCIN TO BE USED IN A STATE SANATORIUM

Sanatorium..... Amount requested.....
(or outside agent)

Patient's Name..... Age.... Sex.... Color.... Marital..

Address .....

Acid Fast Bacilli Yes..... No..... Not known.....

Present body weight.....

Please submit the following:

A. 1) Summary of history, medical findings and course of disease.
2) Pertinent laboratory findings.
3) Why streptomycin seems indicated and how it fits into the overall plan for therapy for this patient.
4) Signature of physician making request.

B. 1) Representative x-ray films.

THE PRESENT STATUS OF STREPTOMYCIN IN THE TREATMENT OF TUBERCULOSIS

Properly employed, streptomycin shows every romise of great usefulness as a most important adnct to the conventional methods of treatment of iberculosis in selected cases. Determinaton of osage, and indications and contraindications for the e of streptomycin are as yet in the formative stage. oxic manifestations, the development of drug stness and the nature of the disease itself are facrs contributing to the difficulty of proper selecon of cases and adequate dosage determination.

Experience gained so far in the use of streptomyn in Connecticut State Sanatoria combined with npressions gained from the experience of other vestigators begin to suggest certain general trends hich have led the Medical Advisory Committee to lopt the following criteria as present bases for lection of cases and dosage in tuberculosis.

GENERAL INDICATIONS AND CONTRAINDICATIONS TO THE USE OF STREPTOMYCIN IN TUBERCULOSIS

Since the evaluation of the role of streptomycin in e treatment of tuberculosis is incomplete, indicaons and contraindications are also incomplete. xperience to date, however, suggests certain genral types of tuberculosis in which the use of streptmycin is of more definite value and other general pes in which it seems less advisable to use streptmycin. These two groups are described under alue most apparent and value least apparent, leaving large in-between group on which streptomycin as been less effective or on which streptomycin is ot indicated because of insufficient studies.

ALUE MOST APPARENT

(1) Disseminated miliary and/or meningeal tuberulosis.

(2) Acute exudative pulmonary disease of relavely recent origin and with progressive trend emonstrated or likely, especially where frank aseation and cavitation are absent or are limited extent.

(3) Acute or sub acute disseminated and relatively fine nodular disease which has not responded atisfactorily to conventional treatment.

(4) Cases that reasonably can be expected to be ade suitable for thoracoplasty or other surgical rocedures by using streptomycin to control too ctive or recently progressive disease, especially ctive contralateral disease.

(5) Disease in which it is reasonable to assume that arrest is prevented because of persistent ulcerative disease of the respiratory tract. This may include carefully selected cases with "blocked" thin walled cavities *not* associated with dense fibro-caseous disease.

(6) Disease showing repeated instability which cannot be explained on the basis of chronic cavitation as the source and which by inference is probably due to endobronchial disease which cannot be visualized.

(7) Chronic tuberculous sinuses and superficial tuberculous abscesses. It is recommended that the latter be first incised and drained.

VALUE LEAST APPARENT

(1) Any patient who is doing well or is likely to do well on conventional therapy.

(2) Chronic fibro-caseous or cavernous tuberculosis.

(3) Chronic tuberculous empyema.

(4) Moribund patients.

B. DOSAGE

Recent trends suggest that for optimum therapeutic results a daily dose of 2.0 grams or over is usually excessive and that duration of treatment need rarely exceed 90 days. Toxic manifestations appear to be more frequent at the higher dose level and in patients who are underweight. These observations have led the Medical Advisory Committee to reduce the dose to a lower level compatible with optimum therapeutic results and to relate the dosage to body weight.

1. General maximum dosage of streptomycin advised in the treatment of tuberculosis.

WEIGHT	DAILY DOSE	TOTAL DOSE	LENGTH OF TREATMENT
Under 100 lb.	1.0 gm.	90 gm.	90 days
100 - 150 lb.	1.3 gm.	120 gm.	90 days
Over 150 lb.	1.5 gm.	135 gm.	90 days

Children (under 15 years)

0.1 gm. to 0.13 gm. per 10 lb. of body weight per day for approximately 90 days.

DIVIDED DOSE

Since it appears that adequate therapeutic effects are obtained and that toxic manifestations are not increased (at the lower dose level), it is recommended that:

The daily dose be given intramuscularly in 2 or 3 divided doses.

A single dose should probably not exceed 0.75 to 1.0 gm.

2. Modifications in maximum dosage.

Severely ill patients, patients with extensive pulmonary disease, and patients with lesions of whose response we know little (e.g., G.U. tuberculosis, bone and joint tuberculosis) may be continued on the general dosage regimen for a total of 90 days.

More benign pulmonary lesions, particularly limited disseminated nodular disease and disease showing minor recurrent instability, may be continued on this regimen for less than 90 days—even 42 or 60 days may be adequate for some such lesions and may have the advantage of limiting the likelihood of drug fastness.

Ulcerative lesions of the respiratory tract may be treated for 60 days then reevaluated by repeat bronchoscopy (or appropriate observation). If at this time progress is unsatisfactory, treatment may be continued for an additional 30 days to make a total of 90 days. If at the end of the first 60 days of treatment healing is either complete or progressing satisfactorily, treatment may be discontinued and the lesion observed without treatment for an additional 4 weeks. If relapse or unfavorable trend is observed during this observation period, or if the trend at the end of the observation period is not satisfactory, retreatment for an additional 30 days is recommended.

Sinuses and incised superficial abscesses: In general it is recommended that these cases be treated on daily doses approximately ⅔ the amount recommended under "dosage." If a favorable trend is not observed after 2 weeks, the daily dosage may be raised to the full amount. Treatment should be discontinued as soon as healing is considered to have taken place or at 90 days, depending on which comes first.

3. Miliary tuberculosis and tuberculous meningitis.

These patients are placed in a different category from other patients with regard to dosage. The case of disseminated miliary tuberculosis is treated by intramuscular injection. The case of meningeal tuberculosis is treated by intramuscular and intrathecal injection. The case of combined miliary and meningeal tuberculosis is treated in the same manner and with the same dosage as that used in meningeal tuberculosis. In these 3 types of cases a full course should be given even though the clinical response is manifest in less time.

Intramuscular Dosage

2.0 grams daily in 5 equal doses for 120 days.

Intrathecal Dosage

50-100 mgm. dissolved in 5-10 c.c. of diluent give on alternate days or 3 times weekly for a period o 90 days.

In cases with meningeal involvement, intramuscu lar and intrathecal treatment should be given earl and, if necessary, before bacteriological proof is ob tained. In a patient with acute miliary tuberculosis experience suggests that an increase in spinal flui cell count alone is sufficient indication for intra thecal treatment and therefore routine examinatio of the spinal fluid every 2 weeks during treatmen is recommended in cases of acute miliary tubercu losis. Additional examinations are indicated at an time the clinical condition suggests the need.

C. LABORATORY STUDIES

Special studies, such as caloric tests of the vestibu lar apparatus, hearing tests and drug fastness of th organism are frequently difficult to carry out ex cept on a limited experimental basis.

The following routine laboratory procedures ar however recommended:

BEFORE TREATMENT	DURING TREATMENT
(1) Complete blood count	Once a month
(2) Non protein nitrogen	Once a month
(3) Phenol Sulpho Phtalein	Once a month
(4) Urinalysis	Once every two weeks

A routine sputum culture near the end of treatment may be used to measure drug fastness or may be saved for such purpose in the event that the patient is later considered for a repeat course of streptomycin.

D. EVALUATION OF STREPTOMYCIN IN THE INDIVIDUAL CASE

In any treated case the observer should incorporate laboratory, x-ray and clinical findings with toxic manifestations in an attempt to evaluate the results of streptomycin.

E. REPEAT COURSE OF STREPTOMYCIN

Before considering a repeat course of streptomycin the following studies are recommended:

(1) Evaluation of previous course.

(2) Drug fastness of the organism.

(3) Prognosis as to value of repeat course.

. TOXIC MANIFESTATIONS

(1) Disturbance of the vestibular mechanism—as manifested by vertigo, nystagmus, nausea and vomiting, difficulty in focusing, etc. (this has been the most serious toxic manifestation and is more severe and the incidence is higher on higher dose regimens, but has occurred in some patients treated with as little as 1 gram daily for 42 days only).

(2) Impairment of hearing—observed rarely in patients without meningitis.

(3) Dermatitis of various types.

(a) Acute drug rash with fever, usually morbilliform or scarlatiniform in appearance. This is usually transient and not serious and is commonly controlled by anti-histaminic drugs or by temporarily suspending treatment.

(b) Pruritis.

(c) Urticaria—may be controlled by anti-histaminic drugs but may occasionally make it necessary to stop treatment.

(d) Dryness and scaliness of the skin which may progress to true exfoliative dermatitis. When progressive and severe cessation of treatment is required.

(4) Urinary findings.

(a) Casts, granular type, occur in all cases—transient and not serious.

(b) Renal insufficiency with high N.P.N. and low P.S.P.—most common in patients with renal function already impaired before treatment and may necessitate withdrawal of treatment.

(5) Headache.

(6) Miscellaneous.

There are isolated reports of diarrhea, granulocytopenia, hemopytic anemia, etc., which may be related to streptomycin therapy and may require cessation of treatment. These manifestations appear to occur rather infrequently.

(7) Contact dermatitis—this has been noted in personnel preparing streptomycin for administration and necessitates the use of rubber gloves by the person preparing the solution.

G. GENERAL CONSIDERATIONS

1. It is presumed that a definite diagnosis of tuberculosis will be made before a case is submitted to the Medical Advisory Board.

2. Because of the compensating factor of vision in relation to vestibular damage, particular attention should be directed to the dangers of administration of streptomycin to persons with impaired vision.

3. If definite relapse occurs during streptomycin therapy, it is suggested that this is an indication that favorable results are not to be expected and discontinuance of the drug is recommended.

4. If streptomycin is being used in preparation for thoracoplasty, or other major surgery, which cannot be given immediately, it is suggested that streptomycin be administered for 6 weeks only, and then withheld until thoracoplasty is imminent. In this way the development of drug fastness will be less likely, and the remainder of the course may then be given during and after thoracoplasty with the maximum likelihood of adequately protecting the patient at that time.

5. Streptomycin may be justified purely for symptomatic relief in patients unlikely to recover but who have severe symptoms from laryngeal or intestinal tuberculosis which cannot be controlled by conventional therapy. In such cases it is recommended that short courses of only approximately 2 weeks be employed. Such short courses may then be repeated if recurrence of such severe symptoms makes this necessary.

6. A major deterrent to the indiscriminate use of streptomycin is the fact that a considerable proportion of patients treated longer than from 2 to 3 months develop predominant strains of tubercle bacilli resistant to the action of the drug. While the clinical significance of this is not yet completely understood, it appears probable that streptomycin is no longer therapeutically effective once significant resistance has developed. Until the significance of this phenomenon (or ways of avoiding it) is clear, this fact, along with toxic manifestations, make it particularly important that patients not be treated with streptomycin so long as prognosis with conventional methods of therapy is reasonably good.

156TH ANNUAL MEETING

PRELIMINARY ANNOUNCEMENT

- The 156th Annual Meeting of the Society will be held at the Roger Ludlowe High School, Fairfield, Wednesday and Thursday, April 28 and 29.
- Papers will be presented by guest speakers each morning. Symposia and section meetings will be held each afternoon.
- The House of Delegates will meet all day Tuesday, April 27, at the Hotel Stratfield, Bridgeport.
- The annual Banquet of the Society will be held at the Hotel Stratfield, Wednesday evening, April 28.
- The Woman's Auxiliary will meet at the Brooklawn Country Club, Bridgeport, Wednesday afternoon, April 28.
- Luncheons during the annual meeting will be served in the cafeteria of the Roger Ludlowe High School.
- Convocation of the Society and introduction of new officers will be held Thursday noon, April 29.

The annual meeting is being arranged by a committee of the Fairfield County Medical Association, as follows: Joseph H. Howard, chairman; Max H. Eddy, George A. Buckhout, William Curley, and John Buckley. The program is being planned by the Society's Program Committee, members of which are Samuel C. Harvey, chairman, New Haven; Carl E. Johnson, New Haven; Maurice T. Root, West Hartford; and John F. Fulton, New Haven, associate member.

Technical Exhibits

Space Number	*Firm*	*Location*
1 and 7	Surgeons and Physicians Supply Company	Boston
2 and 3	Professional Equipment Company	New Haven
4	Spencer, Inc.	New Haven
5	E. F. Mahady Company	Boston
6	Burroughs Wellcome and Co., Inc. (U. S. A.)	New York
8 and 9	Brewer and Company, Inc.	Worcester
10	Doho Chemical Corporation	New York
11	Ciba Pharmaceutical Products, Inc.	New Jersey
12	Philip Morris and Company, Inc.	New York
13	White Laboratories, Inc.	Newark
14	H. W. Kinney and Sons, Inc.	Indiana
15	Mead Johnson and Company	Evansville
16	Nestle's Milk Products, Inc.	New York
17	Van Pelt and Brown, Inc.	Richmond
18	G. D. Searle and Company	Chicago
19	E. L. Washburn and Company	New Haven
20	E. R. Squibb and Sons	New York
21	Wm. P. Poythress and Co., Inc.	Richmond
22	D. G. Stoughton Company	Hartford
23	Smith, Kline, and French Laboratories	Philadelphia

156TH ANNUAL MEETING

The Connecticut State Medical Society

GENERAL PROGRAM

ROGER LUDLOWE HIGH SCHOOL, FAIRFIELD, APRIL 28 AND 29, 1948

Wednesday, April 28

JAMES R. MILLER, *President, presiding*

9:00 REGISTRATION

9:20 MOTION PICTURE

9:45 CALL TO ORDER
ADDRESS OF WELCOME—J. Grady Booe, president, Fairfield County Medical Association

10:00 SOME HARMFUL EFFECTS OF IRRADIATION
W. Edward Chamberlain, *Professor of Radiology, Temple University Medical School*

10:30 WHAT THE GENERAL PRACTITIONER SHOULD KNOW ABOUT DERMATOLOGY
George C. Andrews, *Associate Professor of Dermatology, Columbia University College of Physicians and Surgeons*

11:00 MOTION PICTURE

11:15 DIAGNOSIS AND TREATMENT OF CRANIAL INJURIES
E. Jefferson Browder, *Professor of Clinical Surgery, Long Island College of Medicine*

11:45 INTEGRATION OF ANESTHESIOLOGY IN MEDICINE
Edward B. Tuohy, *Professor of Anesthesiology, Georgetown Medical Center*

12:15 PRACTICAL METHODS OF IMMUNIZATION
John E. Gordon, *Professor of Epidemiology, Harvard School of Public Health*

12:45 LUNCHEON

2:15 MOTION PICTURE

2:30 SYMPOSIUM ON GYNECOLOGY—Emil Novak, Chairman

1. OFFICE GYNECOLOGY
Emil Novak, *Assistant Professor of Gynecology, Johns Hopkins School of Medicine*
2. HORMONES IN GYNECOLOGY
Jacob Hoffman, *Instructor in Gynecological Pathology, Jefferson Medical College*
3. THE VAGINAL SMEAR AND THE "SURFACE-BIOPSY" METHOD: AIDS TO DIAGNOSIS IN GYNECOLOGY
J. Ernest Ayre, *Director, Gyne-Cytology Laboratory, Royal Victoria Hospital, Montreal*

3:30 MOTION PICTURE

3:45 PANEL DISCUSSION—Drs. Novak, Hoffman, Ayre and others

Thursday, April 29

9:00 Registration

9:20 Motion Picture

9:45 Laxatives and Cathartics
William T. Salter, *Professor of Pharmacology, Yale University School of Medicine*

10:15 Differential Diagnosis of Coronary Disease
H. M. Marvin, *Associate Clinical Professor of Medicine, Yale University School of Medicine*

10:45 Motion Picture

11:00 Infectious Hepatitis
Joseph Stokes, Jr., *Professor of Pediatrics, University of Pennsylvania School of Medicine*

11:30 Dehydration and Electrolytes
Charles R. Drew, *Director of the Department of Surgery, Howard University School of Medicine*

12:00 Convocation of the Society
Address of the Retiring President, James R. Miller
Introduction of the President-Elect and Officers for 1948-1949

12:45 Luncheon

2:15 Motion Picture

2:30 Symposium on Alcoholism—Charles T. Bingham, Chairman

1. Sociological and Economic Aspects
Selden D. Bacon, *Associate Professor of Sociology, Yale University; Chairman, Connecticut Commission on Alcoholism*
2. The Alcoholic Personality from the Psychiatric Point of View
Harry M. Tiebout, *Physician-in-Charge, Blythewood Sanatorium*
3. Alcoholism as a Medical Problem
Howard W. Haggard, *Director, Laboratory of Applied Psysiology, Yale University*

3:30 Motion Picture

3:45 Panel Discussion—Mr. Bacon, Drs. Bingham, Tiebout, Haggard and Benjamin H. Gottesfeld

THE SECTIONS OF THE SOCIETY, WHICH WILL MEET ON WEDNESDAY AND THURSDAY AFTERNOONS, HAVE NOT YET COMPLETED ARRANGEMENTS FOR THEIR PROGRAMS. FULL DETAILS OF THESE MEETINGS WILL BE PUBLISHED IN THE APRIL ISSUE OF THE JOURNAL.

NOTE: The general subjects listed in this announcement will be replaced in the final program with specific topics for each speaker.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Socialized Medicine

It should be profitable to consider in brief the tuation in Great Britain and in this country at the resent time with regard to socialized medicine. In he former country great changes in sociomedical elationships are about to take place, for on July 5 f this year the Labour Government proposes to ay everybody's doctor and dentist bills and, in ddition, bills for hospital care, ambulance service, rugs and medical supplies. The Government proposes to collect in taxes what it needs for this program. There are no limits to the number of treatments or the type of illness treated. Specialists, ncluding surgeons and psychiatrists, will be assigned o hospitals and health centers, and will also be available for home calls. Home nursing and midwife ervices will also go on the free list.

The physician is free to join the Government ealth plan or not. If he does he receives a basic alary of $1,200, plus a limited fee for each patient. After the system is operating, the Government will ave the authority to refuse to enlist doctors in areas which it regards as sufficiently supplied. These, in he main, are the essentials of the system of socialzed medicine which the British Medical Association re asked to support. That body, however, is asking or many basic changes in the new law but the proponents of the program feel that such opposition will not be effective. It is pointed out that but 65 per cent of physicians in Great Britain belong to he Medical Association, and that the attempt to boycott the 1912 low income health insurance by that body ended in failure.

The interest in the socialization of medicine in our own country centers around two important bills which are before the Congress, namely, S1320 and S545. The former, introduced by Senator Murray and others, contemplates a nationwide tax collected by payroll deductions of workers in industry and other taxes on non payroll citizens, in return for which tax the Federal Government assumes the responsibility for the overall medical care of all the people. Provisions for certain decentralization of administration is made in the bill.

Bill S545, introduced by Senator Taft and others, on the other hand, contemplates Federal grants to the several States and challenges the States to develop their own programs for taking care of the health needs for the people within their respective jurisdictions. No special ear-marked tax is proposed under the plan. Interest bearing on opinions supporting these bills is seen in the answers to a letter sent to the Governors of the 48 States by Senator H. Alexander Smith, chairman of the Subcommittee on Health. An analysis of replies shows that 25 Governors favor S545, with or without qualifications, 1 (Utah) favored S1320, 8 indicated no preference, 5 not in favor of either, 9 reports not yet submitted.

Concerning this latter bill (S545), an interesting recommendation has come recently from the Medical Society of the State of New Jersey to the effect

that the bill should be amended so that grants-in-aid under title VII go only to States that can show need for Federal aid. This brings up the question as to whether it might be sound practice for the Government to review the entire matter by making unbiased surveys of the complete national health picture before taking action on any measure. A suggestion has been made that this might be done by county surveys compiled by an unbiased civilian committee comprised equally of research analysts and doctors of medicine, and appointed by the Congress.

The socialized medicine program which is about to be inaugurated in Great Britain shows to what length such planning can go if it is not properly guided, and if the medical profession has but little share in its construction. The profession in our country are certainly not opposed to change but they seek evolutionary change which provides the public with increased opportunity for more and improved medical care, and protect them from revolutionary disorderly change. In this they are in agreement with the recent statement of Senator Leverett Saltonstall: "The whole question of medical self-help versus government aid is hard to resolve. The Blue Cross and the various systems of self-help should be carried as far as possible. Doctors must be left as free for their private practice as possible. If doctors become bureaucrats, they lose their initiative; and the advancement of medicine finishes. Yet government cannot shirk its responsibility to those of our citizens who need its help."

The County Medical Association

The special meetings of the county medical associations, which were held in January, were important if for no other reason than that many physicians became really aware of the true position of the county association in organized medicine. It must be clear to those who realize the real structure of our State Society that any criticism directed toward that body is directed chiefly to the House of Delegates, whose deliberations determine the policy of the Society and who therefore are primarily responsible for the various activities of the Society. The Council and Officers of the Society are, and always have been, keenly aware of their subordinate relationship to this larger group who represent, in turn, the county medical associations. It hardly seems necessary to remind each member of the county medical association that, if the democratic process of procedure is to be carried out, the importance of his attendance at the county meetings cannot be overemphasized. That these opportunities have been neglected in the past in most county associations is well known to those who attend the business meetings. It is not unusual for such meetings to be conducted with but few more members than the proverbial "baker's dozen." However, the recent special meetings seem to have demonstrated an awakened interest in affairs and, also, that a renascence of the county association as the all important basic political unit of the State Society is something more than simple hope. Other signs of awakening are seen in the establishment in some counties of an active board of directors, who meet at stated intervals between regular meetings to discuss not only the immediate affairs of the association, but social and professional relationships within the county. It is only in this way that the county medical association can and should be the most important organization in each county in matters pertaining to health.

In accepting these important responsibilities which rest in the county association, serious effort should always be made to select officers and representatives on the basis of leadership and efficiency. To be selected by one's colleagues for such honor means that the office should not be accepted unless time and effort can be given for its proper service. "If medicine is to lead and not be led" says President L. H. Bauer of the Medical Society of the State of New York, "then the County Medical Society must be rejuvenated."

Sodium Fluoride and Dental Decay

The Connecticut State Department of Health through its Bureau of Maternal and Child Hygiene recently issued to all physicians in the State a circular letter[1] entitled "Topical Applications of Sodium Fluoride." This letter together with its accompanying folder from such an authoritative source brings into focus the results of research carried on in various sections of the United States during the past 15 years, but more intensively since 1944. Certain facts have been established regarding (1) the possible ways in which fluorides, in natural sources and added artificially, may be used in the reduction of the dental caries experience, and (2) the mechanism through which the fluorides act in this reduction. Another field of research has concerned itself with

1. Conn State Dept. Health, Circular Letter No. 2, February 3, 1948.

he effect of topical applications of sodium fluoride.

Dental decay has been found to be reduced by luorine in water and food by 40 per cent. The greatst benefit occurs in the ages from birth to 8 years where there has been continuous exposure to domesic water supplies containing around 1 part of luorine per million parts of water. It is presumed hat fluorine thus ingested during the years of tooth levelopment attracts calcium from the surroundings nd from saliva and becomes caries-resistant calcium luorapatite. Drinking water containing more than 1 part per million results in chronic fluorosis, evidenced by brown scars on the teeth. The danger does not seem to exist so much in water containing natural fluorine over that strength as in water to which more than that amount has been artificially added. No fluorine toxicosis has been found related to skeletal storage with the domestic use of fluorine containing water even up to 14 parts per million, as in the case of drinking water in Bauxite, Arkansas.

Many communities have been adding fluorides to their water supply under carefully controlled conditions to bring the fluorine content up to 1 part per million. In Connecticut, beginning April 30, 1945 the water supply at the Southbury Training School was treated with sodium fluoride in the proportion of 1 part per million. The evidence presented[2] thus far demonstrates an effectiveness in the reduction of the incidence of new caries probably greater than 25 per cent. Certain towns in Illinois using a water supply of relatively high fluoride content have shown a percentage of caries-free children about 6 times as great as in neighboring towns using fluoride-free water from Lake Michigan.[3]

The greatest benefit from topical applications of a 2 per cent sodium fluoride comes during the early life of the permanent teeth (from 5 to 12 years). Fluorine thus applied is absorbed directly into erupted teeth and becomes calcium fluoride which is also caries-resistant. This has resulted in 21 to 50 per cent inhibition of new dental caries. The American Dental Association has gone on record as favoring the use of topical applications of 1 and 2 per cent solutions of sodium fluoride to children—especially to newly erupted permanent teeth—for the prevention of significant amounts of dental caries. These topical applications to be effectual should be carried out by a dentist. Experiments have been performed using tooth powders containing rock phosphate with some reduction in carious lesions. This method is probably impractical since much of the material may be left accidentally in the oral cavity and subsequently swallowed.

The real proof of the benefit from adding fluorides to domestic water supply will not be available till about 1960. Topical application of sodium fluoride already has produced sufficient evidence of its value in reducing dental caries to receive the hearty support of physicians. Parents should be encouraged to make certain that children receive this treatment by their dentists.

2. Conn. Health Bull., Jan. 1948.
3. Stadt, Z. M., N.C. Med. Jour. IX, i, Jan. 1948.

National Blood Program of the American Red Cross

With the opening of the Regional Blood Center at Rochester, N. Y., on January 12, the American Red Cross inaugurated one of the most important peacetime health projects ever undertaken by the organization.

The new National Blood Program of Red Cross will take the form of a nationwide network of blood centers, of which Rochester is the first. There will follow in quick succession similar centers in Wichita, Kan.; Atlanta, Ga.; Washington, D. C.; Stockton, Calif.; and Louisville, Ky. By the end of the year it is anticipated that 50 regional centers will be in operation.

This is a long range project and it is estimated that it will take from three to five years to reach full development.

Present plans call for the establishment of approximately 140 metropolitan centers throughout the country, with 250 secondary centers in smaller communities and several hundred mobile units to serve rural and suburban areas.

Both fixed centers and mobile units will be staffed by highly trained professional personnel and will operate under the technical guidance of medical advisory committees appointed at the local level.

The new blood program is designed to furnish whole blood and, in time, blood derivatives of proven clinical value to all of the nation. It is an outgrowth of the cooperative wartime blood program of the Red Cross, the armed forces and the National Research Council. The project was launched by Red Cross after consultation with lead-

ers in the American Medical Association, the American Hospital Association, the U. S. Public Health Service, the Army, the Navy and the Veterans Administration.

Blood of voluntary donors will be taken in centers and mobile units, then processed and distributed to hospitals on the basis of medical requirements. The entire cost of collecting, processing and distributing the blood will be borne by the Red Cross. Blood will be supplied patients without cost, the only charge to the recipient being the normal medical or hospital fee in connection with its administration.

The primary objective of the program will be to furnish whole blood for treatment of both surgical and medical patients in civilian, service and public health hospitals. Once the program has reached the stage where sufficient blood is available a part of it will be processed into plasma and subsequently fractionated into its derivatives. These fractions will be distributed free of charge to physicians through state health departments.

Medical authorities estimate that approximately 3,700,000 donations will be required annually to meet national medical needs in treating the ill and injured.

When the program has reached full development it is expected that sufficient blood and blood derivatives will be available to meet all medical requirements.

The Medical and Hospital Plan Merger

The acceptance by Dr. Paul R. Hawley, ex-chief of Veterans Administration medical and hospital services, of the executive leadership of both the Blue Cross Commission and Associated Medical Care Plans represents an important step in the promotion of voluntary prepayment plans. In his acceptance speech Dr. Hawley said, "I have been told by so-called experts that this undertaking is too gigantic for a private, voluntary agency and that only the government is in a position to make it successful. I would have no quarrel with this point of view except that it is invariably coupled with the provision that, to make it successful, the government would have to control medical practice. Nor would I object to the government control of medicine if this would elevate the standard of medical practice in this country. But I have seen government medicine in operation in other countries and I know what government control does to medicine. I wa no part of it for our people." The reaction of th Congress on the Hawley appointment will also b important. He is recognized for his great abilit in the field of medical administration and his sin cerity of purpose and judgment are unquestione by those who know his record. The plans call fo a merging of the two plans with the appointmer of prominent laymen to the policy-making boar of the new organization. Also, the setting up of national insurance company to enroll employees o industries that operate in more than one stat Whether these objectives will be completed in 194 remains a question. It is certain, however, that man leaders of medical thought welcome this realisti approach to the problem of medical and hospita insurance.

A Connecticut Physicians' Art Exhibit

Interest in a hobby should be a natural develop ment for the doctor if he has the wisdom to take th advice he so often gives others. Ever since th formation of the American Physicians Art Associa tion, a number of Connecticut physicians have bee active as members and as exhibitors; some have bee noteworthy prize winners. The plan to have a exhibit of physicians' art at the annual meeting i Fairfield is therefore a welcome announcement be cause it will give us an opportunity to see for our selves what our brothers are doing in their variou fields of art. American physicians long have had a interest in the field of art both as collectors and a artists. Some have attained real eminence such a Alexander Anderson of New York who in the be ginning of the last century established wood engrav ing as a great art in America, and at a later dat Tait Mackenzie, who as a sculptor became world renowned.

All physicians interested in submitting work fo the exhibition at the annual meeting are invited t write to Dr. Robert J. Hansell, 45 East Putnam Avenue, Greenwich.

The First Cancer Conference

Every physician who sees patients for whatever reason must become cancer conscious if he is t assume the full responsibility which society has en trusted to him. This applies alike to specialists and general practitioners, for no matter how restricted the special field in which one practices, the visit t

he doctor may reveal early symptoms of the disease any part of the body. It is not infrequent for the atient himself to inadvertently refer to an apparntly mild disturbance which, if intelligently investigated, will prove to be a beginning cancer. The ancer Conference which will be held in New laven on March 25 offers an unusual opportunity or physicians to become familiar not only with the nportant clinical aspects of the disease, but also ith the opportunities within our state for treatent according to the most modern standards. The ommittee which has planned this event are to be ommended for the high excellence of the program, nd it is certain that many physicians will see the nportance of attending.

Student Members to Receive Complimentary Subscriptions

Student members of our Society are allowed to urchase a yearly subscription to the JOURNAL at ne half the regular price: namely, $2.50. A numer of students have availed themselves of this opportunity, which offers them a chance to become amiliar with scientific progress in medicine and vith medical affairs back home. From the point of iew of the Society it is an excellent way for us to e in touch with these young men and women, for ve can feel assured that through the JOURNAL we an express the attitude of our thinking concerning uestions that have social and economic significance. Bearing in mind these things, the Board of Directors f the New Haven County Medical Association has ecently voted to present a complimentary subscription to the JOURNAL to each student member whose home is in New Haven County. This decision sets an example which other County associations well could consider.

American Academy of General Practice

The American Academy of General Practice was founded June 10, 1947, by the officers and members of the Section in General Practice of the AMA at the meeting in Atlantic City. The new Academy is an organization independent and distinct from the American Medical Association, although members must be also members of the AMA. The purposes for which the Academy was founded are seen in the following quotation from the Constitution:

1. "To promote and maintain high standards of the general practice of medicine and surgery.

2. "To encourage and assist young men and women in preparing, qualifying, and establishing themselves in general practice.

3. "To protect the right of the General Practitioner to engage in medical and surgical procedures for which he is qualified by training and experience.

4. "To assist in providing postgraduate study courses for General Practitioners, and to encourage and assist practicing physicians and surgeons in participating in such training.

5. "To advance medical science and private and public health."

Qualifications for membership include actual participation in general practice for at least three years, high moral and professional character, a year's rotating internship in an approved hospital or the equivalent in postgraduate training. In addition members will be required to devote at least 150 hours during every three-year period to postgraduate study—credit to be given for attendance at various medical meetings. Provision is made also in the By-Laws for the establishment of state and county branches. An initiation fee of $10 and yearly dues of $15 are stipulated. An application for membership form may be obtained from Dr. Stanley R. Truman, secretary, 1904 Franklin Street, Oakland 12, California.

One of the important things that such an organization can do would be to stimulate the establishment of postgraduate training programs for the general practitioner. For this reason, if for no other, the organization could have an important effect upon medical practice in this country.

California Outlaws Rebates

The executive committee of the California Medical Association has instructed its legal advisers to draft legislation providing heavy penalties for violation of the law forbidding physicians to accept rebates, kickbacks, and commissions. These penalties will apply to both physicians and laboratories engaged in selling supplies and appliances.

THE PRESIDENT'S PAGE

Is the Connecticut State Medical Society constituted to meet present day needs? The New England town meeting in its day was admirably suited to the needs and the temperament of our small communities. Many of our state medical societies still function efficiently on the basis of county societies which meet every month and where all members know each other. These county societies constitute the principal and often the only medium of expression for physicians.

In most Connecticut large towns and cities, however, the physician has lost his reliance on the county association. It meets but twice a year. He satisfies his thirst for scientific knowledge and for social intercourse in the more frequent meetings of his hospital staff and of his local medical society. In these groups he is seldom bothered by discussions of the rights, privileges and duties of the profession as a social organism. Hence in Connecticut the State Medical Society has been forced to develop itself to meet this need though it has incessantly tried to put flesh on the bones of the county associations. This does not, of course, apply to some of our thriving smaller county groups.

During the present consideration of the Prepaid Medical Insurance Program it has become apparent that when physicians are deeply aroused on a subject which affects the practice of medicine itself, the principal forum for discussion is the hospital staff, and we have observed action in the meetings of the county associations as the result of opinions which have been formed in a series of caucuses.

All of this is healthy if only the minority opinion is not stifled and if ample opportunity is given to elicit expression from the less articulate members of our profession. It must be remembered that many of our members do not participate in these staff discussions.

During the recent meetings of county associations the question of instructed delegations has been raised. There is nothing in our by-laws nor indeed in Roberts' Rules of Order which provides for unit rule. It would seem appropriate, if when a vote is taken and recorded as 60 to 40 on a given question, that the delegates of that association vote in about the same ratio for and against the question when it is raised on the floor of the House of Delegates. Otherwise the voice of the minority is suppressed.

An able committee is studying the reorganization of our State Society at the present time. It seems most desirable to recognize in this reorganization the importance in the life of the physician of his local and hospital staff organization; in the case of specialists consideration might be given to his specialty group. In one way or another account must be taken of these facts, for the organized profession already is being called on to negotiate with government on many problems affecting the practice of medicine. It is not too early for us to begin to think of the motto, "United We Stand, Divided We Fall."

James R. Miller

THE SECRETARY'S OFFICE

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CONFERENCE OF COUNTY AND STATE OFFICERS

Thursday, March 18, 1948, 4:30 P. M.

New Haven Medical Association, 364 Whitney Avenue

PROGRAM

1. Call to Order
   James R. Miller, President
2. The Importance of the County Association in Relation to the State Society and the American Medical Association (this discussion requested by county officers)
   Creighton Barker
3. Exemption from Dues and Dues Collection
   Grace Mooney
4. Student Membership: Objectives and Future Development
   Herbert Thoms
5. Information Service for Members of the Society
   James G. Burch

DINNER

6. Round table discussion: Thomas P. Murdock, leader
   C. C. Bishop, G. A. Buckhout, T. J. Danaher, W. H. Lowell, Jr.

   These questions have been suggested for discussion by members of the Conference:
   1. How do County Associations handle business which does not need to be referred to the Directors, Trustees or the entire membership?
   2. How are new members attracted by County Associations and how are they investigated?
   3. How can interest in County Association meetings be stimulated and what kind of programs should be arranged?
   4. What information should be provided for County Associations before meetings of the House of Delegates?

January Council Meeting

The monthly meeting of the Council was called to order at five o'clock in the afternoon of January 28, 1948 at the Hartford Club, Hartford. There were present: Dr. Murdock, the Chairman, Drs. Thoms, Parmelee, Speight, Phillips, Harvey, Gibson, Weld, Burlingame, Howard, Gildersleeve, Miller, Barker and Miss Mooney. Absent: Drs. La Moure, Weed. This meeting followed immediately after a special meeting of the House of Delegates which had been called to act upon the report of the

Society's Committee on Prepaid Medical Service tabled at the interim meeting of the House of Delegates held in New Haven on December 4, 1947.

NEW STATE FOOD AND DRUG COMMITTEE

The Council voted to approve a proposal from the Joint Conference Committee of the Society and the Connecticut Pharmaceutical Association that the Society participate in a new Connecticut Committee on Food, Drugs, Cosmetics, and Devices.

STUDENT MEMBERS

Forty student members were elected to the Society and a list of them is published herewith.

CONFERENCE OF COUNTY AND STATE OFFICERS

It was voted to hold the 1948 spring Conference of Presidents and Secretaries of the County Associations with the Council of the Society on March 18 in New Haven.

DUES EXEMPTION FOR COUNTY SECRETARIES

The Secretary was instructed to communicate with the secretaries of component County Associations calling attention to the fact that there is now no provision in the By-Laws of the Society for exemption of county secretaries from the payment of dues.

AMENDMENTS TO BY-LAWS

It was voted that the Secretary prepare an amendment to Article X, Section 3, Paragraph 2, of the By-Laws of the Society discontinuing the Committee on the Clinical Congress and replacing it with a Committee on Postgraduate Education.

The Secretary was also instructed to prepare an amendment to Article X, Section 3, Paragraph 12, of the By-Laws changing the name of the Committee on Tumor Study to the Cancer Committee and restating the functions of the Committee.

NEW ENGLAND HEART ASSOCIATION

The action of the President of the Society in approving the current project of the New England Heart Association was confirmed by the Council.

NOMINATIONS FOR 1948-1949

Nominatons for officers and committees of the Society for 1948-1949 were made for presentation to the House of Delegates at the Annual Meeting on April 27, 1948.

It was voted that the next meeting of the Council be on Friday, March 5, 1948.

STUDENT MEMBERS

Micahel D. Albis, New Haven
Marquette University School of Medicine
Milwaukee, Wisconsin—Class of 1948
Pre-med: Fordham University
Parent: Michael Albis, 273 Lighthouse Rd., New Haven

Alyce B. Albrecht, Stratford
Long Island College of Medicine, Brooklyn, N. Y.—Cla of 1951
Pre-med: Ursinus College, Collegeville, Pa.
Parent: Alfred P. Albrecht, 81 Wyoming St., Stratford

Bernard Beatman, New Britain
Albany Medical College, Albany, N. Y.—Class of 1951
Pre-med: Wesleyan University
Parent: Raymond D. Beatman, 209 Columbia St., New Britai

Leo Blank, Hartford
Medical College of Virginia, Richmond, Virginia—Class o 1949
Pre-med: Trinity College .
Parent: William H. Blank (deceased), 66 Adams St., Hart ford

John E. Borowy, Stamford
Yale University School of Medicine—Class of 1950
Pre-med: University of Connecticut, Storrs, Conn.
Parent: Frank Borowy, 23 Woodrow St., Stamford

Eric T. Carlson, Norwich
Cornell University Medical College, New York—Class o 1950
Pre-med: Wesleyan University
Parent: Erick V. Carlson, 84 Washington St., Norwich

Harold A. Carlson, Jr., Stratford
New York Medical College, New York City—Class of 194
Pre-med: Colgate University
Parent: Harold A. Carlson, 210 Rockwell Ave., Stratfor

John Caruso, Jr., New London
Boston University School of Medicine—Class of 1949
Pre-med: Harvard College
Parent: John Caruso, 20 West Coit St., New London, Conn

George O. Clifford, Jr., Southport
Tufts College Medical School, Boston—Class of 1949
Pre-med: Harvard
Parent: George O. Clifford, Pequot Road, Southport

John F. Cohane, New Haven
New York Medical College, New York City—Class of 195
Pre-med: Trinity College
Parent: Timothy F. Cohane, 398 Congress Ave., New Haver

Alice C. Ente, Bridgeport
New York Medical College, New York City—Class of 1951
Pre-med: Tufts College
Parent: Joseph Ente, 1269 Stratford Ave., Bridgeport

Mary T. Foley, New Haven
Tufts College Medical School, Boston—Class of 1951
Pre-med: Regis College, Weston, Mass.
Parent: Francis E. Foley, 588 Ferry St., New Haven

Reginald J. E. Fournier, East Hartford
Tufts College Medical School, Boston—Class of 1950
Pre-med: Bates College, Lewiston, Maine
Parent: Thomas J. Fournier, 2 Norman Rd., East Hartford

obert W. Frederickson, New Britain
ew York Medical College, New York City—Class of 1951
re-med: Trinity College
arent: Eric A. Frederickson, 76 Garden St., New Britain

ving Glassman, West Haven
ew York Medical College, New York City—Class of 1951
re-med: Bethany College, Bethany, West Virginia
arent: Louis Glassman, 165 Center Street, West Haven

iles S. Golden, Bridgewater
ong Island College of Medicine, Brooklyn, N. Y.—Class of 1948
re-med: Harvard
arent: Ben Golden, Bridgewater, Conn.

onald S. Hauss, New London
Western Reserve University School of Medicine—Class of 1948
re-med: Amherst College
arent: Morris Hauss, 72 Lincoln Ave., New London, Conn.

Herbert H. Herr, Jr., Guilford
Tufts College Medical School, Boston—Class of 1949
re-med: Trinity College
arent: Herbert Harvey Herr, West Lake, Guilford

oseph L. Horowitz, Bridgeport
New York Medical College, New York City—Class of 1949
re-med: Yale University
arent: Abraham Horowitz, 415 State St., Ext., Bridgeport

Thomas J. Impellitteri, New London
Marquette University School of Medicine
Milwuakee, Wisconsin—Class of 1949
Pre-med: University of Connecticut, Storrs
Parent: Anthony Impelitteri (deceased), 14 Lincoln Court, New London

Coleman Jacobson, Iowa
University of Iowa, Iowa City, Iowa—Class of 1949
Pre-med: University of Connecticut and Univ. of Iowa
Parent: David Jacobson, 508 Brown St., Iowa City, Iowa

Samuel A. Johnson, New Britain
Columbia University College of Physicians and Surgeons, New York City—Class of 1949
Pre-med: Harvard
Parent: Herbert E. Johnson, 785 Corbin Ave., New Britain

Ralph D. Junker, Ansonia
Columbia University College of Physicians and Surgeons, New York City—Class of 1950
Pre-med: Carleton College, Minnesota
Parent: Reverend Valentine Junker, 45 Jackson St., Ansonia

Edward A. Kamens, Bridgeport
University of Vermont College of Medicine, Burlington, Vermont—Class of 1951
Pre-med: Johns Hopkins University
Parent: Samuel Kamens, 190 Eaton St., Bridgeport

Robert W. Kircher, East Norwalk
Cornell University Medical College, New York City—Class of 1948
Pre-med: Wesleyan University
Parent: Stacy G. Kircher, 29 Fifth St., East Norwalk

Robert I. Lowenberg, Newington
New York University—June 1942
Intern at Veterans Hospital, Newington until Fall of 1948
Parent: Samuel W. Lowenberg, 47 W. Robbins Ave., Newington

Nicholas A. H. Marzialo, Hartford
Tufts College Medical School, Boston—Class of 1948
Pre-med: Trinity College
Parent: (father deceased) 10 Kilbourn St., Hartford

Tilford D. Miller: Wilton
Cornell University Medical College, New York—Class of 1950
Pre-med: Amherst College
Parent: Tilford W. Miller, Belden Hill Road, Wilton

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Pre-med: University of Connecticut
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Pre-med: Wellesley College
Parent: Robert H. W. Strang, 128 Toilsome Hill Road, Bridgeport

Richard H. Tapogna, Hartford
Loyola University—Class of 1950
Pre-med: Trinity College
Parent: Joseph Tapogna (deceased), 130 Cromwell St., Hartford

Vernon E. Thomas, Hartford
New York Medical College, New York City—Class of 1951
Pre-med: Trinity College
Parent: John I. Z. Thomas, 138 Cornwall St., Hartford

Hartwell G. Thompson, Jr., West Hartford
Cornell University Medical College, New York—Class of 1950
Pre-med: Yale University
Parent: Hartwell G. Thompson, 184 Mountain Road, West Hartford

Eugene R. Tompkins, Jr., Hartford
University of Vermont College of Medicine, Burlington, Vt.—Class of 1949
Pre-med: Middlebury College, Middlebury, Vermont
Parent: Eugene R. Tompkins, 245 Lyme St., Hartford

Earl E. VanDerwerker, Jr., Newtown
Temple University School of Medicine—Class of 1949
Pre-med: Rutgers University
Parent: Earl E. VanDerwerker (deceased), Newtown

Thomas H. Walker, Cornwall
New York Medical College, New York City—Class of 1950
Pre-med: Yale University and Trinity College
Parent: Wilmarth B. Walker, Cornwall

Allen S. Weed, Hamden
Temple University School of Medicine—Class of 1949
Pre-med: University of Maryland
Parent: Stanley E. Weed, 54 Woodin St., Hamden

Anne C. Wollack, Deep River
University of Pennsylvania School of Medicine—Class of 1950
Pre-med: Albertus Magnus College
Parent: Joseph Wollack, 14 West Elm St., Deep River

Michael A. Woodbury, Ridgefield
Harvard University Medical School—Class of 1951
Pre-med: Harvard
Parent: Thornton Woodbury, Jr., Florida Hill Road, Ridgefield

Meetings Held During February

Tuesday, February 17, 4:30 P. M.
Trustees of the Building Fund

Wednesday, February 18, 5:00 P. M.
Committee on Arrangements for Annual Meeting, Bridgeport

Wednesday, February 25, 7:00 P. M.
Committee on Industrial Health

Thursday, February 26, 2:00 P. M.
Conference on Prepaid Medical Care Plan, New Haven Medical Association

4:30 P. M.
Workmen's Compensation Committee, New Haven Medical Association

Meetings Scheduled for March

Friday, March 5
Council of the Society

Monday, March 8, 5:00 P. M.
Committee on Cooperation with Yale School of Medicine

Tuesday, March 9, 10:00 A. M.
Written examinations of the Connecticut Medical Examining Board, State Capitol

Wednesday, March 10: 10:00 A. M.
Written examinations of the Connecticut Medical Examining Board, State Capitol, Hartford

Wednesday, March 17, 4:00 P. M.
Committee to Study Maternal Mortality and Morbidity

Thursday, March 18, 4:30 P. M.
Conference of State and County Officers, New Haven Medical Association

Tuesday, March 23
Executive Meeting, Connecticut Medical Examining Board.

Connecticut Cancer Society

As the year 1948 begins, Connecticut takes inventory of its "assets" with reassurance—faces the coming year with hope and enthusiasm. These are some of the things we are currently thinking about:

OUR INFORMATION CENTERS

These have increased from ten a year ago to 13. With the exception of a few sections of the state, no Connecticut person is more than 25 miles away from an information center.

OUR DETECTION CENTERS

Detection centers are now located in four large communities. Plans are being studied in an additional community for the establishment of a fifth.

OUR PUBLIC EDUCATION WORK

Where there are no information centers, Field Army groups are carrying on active programs. Local work is coordinated through a busy state public education committee.

OUR NEW SOCIAL SERVICE COMMITTEE

A new state committee has been created, with representation from physicians and lay leaders. The group will survey ways of strengthening social service assistance in behalf of cancer patients and will make recommendations to local branches.

OUR CAMPAIGN

State campaign leaders are already busy, aiming once more to have all 169 municipalities of the state covered by a campaign committee. They are urging local committees to make adequate advance preparations.

OUR STATE CANCER CONFERENCE

Late in March, a cancer conference will be held, primarily to attract attendance by general practicing physicians. A special evening session will be open to the public. Theme of the conference: "Every Doctor's Office is a Cancer Detection Center."

CONNECTICUT'S FIRST CANCER CONFERENCE FOR PHYSICIANS

Thursday, March 25, Hotel Taft, New Haven

Arranged by the Connecticut Cancer Society, with the cooperation of the Connecticut State Medical Society

The conference will emphasize the early detection of cancer by family physicians and means available for prompt treatment

MORNING SESSION

Donald A. Bristoll, M.D., presiding

9:00 CANCER FACILITIES IN CONNECTICUT
Creighton Barker, M.D., *president, Connecticut Cancer Society*

9:30 CANCER OF THE SKIN
Jack Wolf, M.D., *New York Skin and Cancer Hospital*

10:00 CANCER OF THE BREAST
Leland S. McKittrick, M.D., *Massachusetts General Hospital*

10:30 CANCER OF THE MOUTH AND LIP
(Speaker to be announced)

11:15 ROUND-TABLE DISCUSSION WITH MORNING SPEAKERS

12:00 LUNCHEON
Speaker: John C. Leonard, M.D., *Hartford Hospital*
Subject: "LABORATORY PROCEDURES"

AFTERNOON SESSION

James R. Miller, M.D., presiding

2:00 THE CANCER PROGRAM IN CONNECTICUT
James R. Miller, M.D., *president Connecticut State Medical Society*

2:30 CANCER OF THE PROSTATE
Wyland F. Leadbetter, M.D., *clinical professor of urology, Tufts College Medical School*

3:00 CANCER OF THE COLON AND RECTUM
Edward J. Ottenheimer, M.D., *Windham Community Memorial Hospital*

3:30 CANCER OF THE UTERUS
J. Vincent Meigs, M.D., *Vincent Memorial Hospital, Boston*

4:00 CANCER OF THE LUNG
Gustaf E. Lindskog, M.D., *associate professor of surgery, Yale University School of Medicine*

4:45 ROUND-TABLE DISCUSSION WITH AFTERNOON SPEAKERS

EVENING SESSION

James R. Miller, M.D., presiding

8:00 AMERICA'S FIGHT AGAINST CANCER
Charles C. Cameron, M.D., *medical and scientific director, American Cancer Society*

MEDICAL PRACTICE GROUP

Connecticut's first full scale medical practice group has been organized by six New Britain physicians.

Members of the group include Donald A. Bristoll, obstetrics and gynecology; Bliss B. Clark, surgery; Louis W. Daley, otolaryngology; George P. Perakos, internal medicine and gastro-enterology; John C. White, internal medicine and cardiology; and Dwight E. Wilson, urology.

The associates are all members of the staff at New Britain General Hospital, and each holds appointment as a chief of service or as a senior in his specialty. They are all certified by their respective specialty boards.

Their practice group was formed only after months spent in studying the development of similar groups in other sections of the country, and gauging the possibilities of success in a typical New England community.

The group is located in a growing industrial city of 80,000 population, the center of a hospital area which serves an estimated 120,000 people. It is housed in a large estate-type home at 32 Grove Hill, once the residence of Mrs. Florence Gates Judd.

The residence has been modified to meet the needs of the group, but this has not been carried to the point of sacrificing the homelike appearance of the interior. Patients appreciate this atmosphere of informality, as has already been evidenced by many expressions of approval. The property is situated a short distance from a busy thoroughfare, near the center of the city. Though removed from downtown traffic and noise, it is readily accessible by automobile and three bus routes. The parking problem has been solved for patients of the group by provision of adequate space on and adjacent to the grounds.

In response to an inquiry from the State Medical Journal, members of the group have told how their group was organized and why, after prolonged study, they decided upon group practice. Their motivations they describe as chiefly two, a conviction that local medical groups can meet in large measure the increasing challenge of government medicine, and a belief that the consolidation of medical practice and facilities at the point of patient contact can produce more efficient medical care at lower costs.

The group has been in existence for only eight months, and its members modestly caution that they cannot present conclusions based on long experience. Yet the problems inherent in bringing together physicians who have been practicing independently, and the means by which they have modified their individual interests to the advantage of the group are matters which have brought many queries from other physicians.

One of the advantages claimed for group practice, the convenience to the patient of having consultant services readily available, has already been demonstrated. At a time when patients are outspokenly concerned over the delays and inconveniences of arranging visits with consulting physicians, the group has found that informal and spontaneous conferences on problems of diagnosis have been frequent and useful.

The advantage of a better distribution of time between office hours and personal pursuits promises early realization for group physicians. Doctors who practice independently are often so tied down by professional responsiblities that it is difficult to arrange adequate time for vacations, postgraduate study, and attendance at medical meetings. Group members explain that the extent to which this disadvantage can be corrected is a subject of current planning.

Plans are also being developed to secure other advantages, such as employment of technical assistants for laboratory and x-ray work, formation of an administrative staff, and the maintenance of a uniform system of clinical records. The clinical record system will provide a complete history and physical record for each patient. These will be maintained in a central file, where they will be readily available to any physician in the group, thus obviating any necessity for duplicate records.

The group hopes in due time to demonstrate that it can provide security for its members against loss from illness, or from absence for the purpose of study, and smooth out some of the inequalities of income which physicians generally experience throughout years of professional activity. A retire-

ment income plan is also being outlined.

The New Britain Medical Group evolved slowly after months of weekly and sometimes semi-weekly discussions. In the course of these discussions a number of seemingly insurmountable problems developed. But in the final organization of the group the difficulties disappeared when it became evident to all its members that each believed implicitly in the integrity of the others, and that unselfish attitudes predominated. Group members emphasize that these qualities are fundamental for the organization of any group. They point out that it took months of discussions and self-education to construct the necessary foundation of mutual agreement.

That medicine is not alone in its concern to provide adequate medical care was illustrated during the formation of the group. The technique of organizing became the sole responsibility of a young attorney in the community, and his enthusiasm awakened the interest of his two partners. Soon all three were engaged in a lengthy study of group medical practice. They contacted other groups throughout the country by letter and telephone, talked to group consultants, acquired information from the American Medical Association, the Connecticut State Medical Society, and other medical organizations. Considerable time was spent with a firm of accountants in Hartford, and here one of the senior partners became so concerned with the problems involved that he produced for the group a valuable store of information regarding sound business organization.

At the conclusion of the study it was the opinion of the attorneys that the group property, including equipment as well as buildings, should be owned by a corporation. The doctors themselves were organized as a limited partnership, and the partnership agreement provides for almost any problem that may arise in the foreseeable future. Division of income among the partners is described in the agreement, which also provides for maintenance of salaries during vacations, periods of illness, and visits to clinics for purposes of study. Funds are to be set aside for retirement, life insurance, and future expansion.

The agreement also provides for the admission of new partners, and voluntary or requested separation. Purchase of equipment, the hiring of professional assistants and non professional personnel, business operation and accounting procedures, relations with associated enterprises, ownership of the reserve funds, voting privileges, and policies of management are additional matters set forth in the partnership agreement.

The introduction of group practice has provoked considerable comment among the other physicians in the community. There has been some apprehension that it might disturb the familiar patterns of practice. But group members believe that the practice of other physicians has not been adversely affected. They feel that since the group is composed of specialists, it is to their interest to maintain good relationships, especially in the matter of referring patients back to their family physicians following consultations or operative procedures. Plans for the growth of the group are expected to provide other branches of the medical specialties and are unlikely to invade the field of the family physician. It is pointed out, however, that no expansion will be undertaken until the present group has been in existence long enough to assure completely smooth operation.

Physicians of the group feel that the soundest advice which they received during their period of organization came from one of their attorneys:

"I have no doubt that each of you at some time during the past eight months has had misgivings and doubts regarding the value of the group and your participation in it. During the hectic formative period such a reaction would be normal, but it should have been just as normal to determine that this group had substance enough to realize its objectives.

"Early in the discussion periods it was once contended that the group had more to offer than benefit to the men comprising it; that the people of this and surrounding communities might be more adequately serviced; that the standard of practice might be raised; that an effective measure of combating socalized medicine might be created; that an institution might be founded which, over a period of years, would allow the establishment of charitable and scholastic funds.

"These factors cannot be ignored because they, and not personal or group benefit, will be the basis for the growth and continuing success of the group. The possibility of failure is remote. Disintegration could occur only because of internal conflict and dissension. It would be astute business to keep the broader aspects and possibilities of this group constantly in mind when discussing problems which will arise."

"DOCTOR'S ORDERS"

A weekly radio series in health education sponsored by the Connecticut State Medical Society — every Sunday at 1:15 P. M., on the Yankee Network.

From inauguration of the series last October through February 15, sixty-eight members of the Society participated in these programs, as follows:

WICC Bridgeport	WONS Hartford	WWCO Waterbury	WNLC New London
Allen F. Delevett	William B. Scoville	John H. Foster	Carl H. Wies
Ellwood C. Weise	E. Myles Standish	Millard C. Hanson	Joseph Becker
George B. Garlick	Walter J. Keefe	Henry Merriman	Henry L. Haines
John W. Buckley	Frederick P. Rogers	J. Harold Root, Jr.	Kathryn E. Verie
Milton M. Lieberthal	John J. Clancy	O. J. Bizzozero	Richard M. Starr
Luther M. Strayer, Jr.	Edward H. Crosby	Maxwell H. Bloomberg	Harold W. Wellington
Kirby S. Howlett, Jr. Shelton	Paul S. Phelps	Cole B. Gibson Meriden	William H. Weidman Norwich
Joseph F. Watts	Henry L. Birge	William M. Good	Robert N. Taylor
Katherine Jean Edgar	Vincent P. Cenci	Sidney W. Jennes	Alfred Labensky
Harold Ribner	Benjamin H. Gottesfeld	Arthur H. Jackson	Sidney F. Drobnes Norwich
Frank Turchik	Edward M. Finesilver	Clarence H. Cole	Frederick B. Hartman
George K. Pratt	Henry B. Moyle	William F. Green Newtown	Riley H. Guthrie Norwich
Vincent A. Lynch	Arthur B. Landry	William Finkelstein	Harold H. Irwin
I. Sidney Zaur	Timothy F. Brewer	Max H. Ruby	Lewis Sears Norwich
Charles H. Sprague	Maurice T. Root	William E. Hill Naugatuck	Lawrence S. Ward
George A. Buckhout	Maxwell O. Phelps	Joseph Sklaver	Bradford B. Crandall Mystic
Edward R. Roberts	Edward H. Truex, Jr.	Milton L. Jennes	Richard A. Loiacono

Important Court Decision

The following decision of the Hartford County Superior Court is of great importance in that it upholds a recommendation of the Connecticut State Medical Examining Board. The court supported the action of the board as a group of medical men, if not experts, in interpreting the testimony of the patient.

No. 76770
NATHAN B. JAFFEE
vs.
STATE DEPARTMENT OF HEALTH
Superior Court
Hartford County
December 8, 1947

MEMORANDUM OF DECISION

This is an appeal to the Superior Court (under the provisions of section 2743 of the general statutes) from a revocation of the plaintiff-appellant's license to practice medicine in Connecticut by the state department of health under the provisions of section 2742 of the general statutes as amended by section 476f of the cumulative supplement thereto. This action followed a hearing by the examining board and a recommendation for such revocation filed by the board with the state department of health.

Since this was an appeal from the finding of an administrative tribunal the burden is on the plaintiff to show that the board acted improperly. Perdue v. Zoning Board of Appeals (1943) 118 Conn. 174, 178.

In this case there is a complete transcript (Ex. E) of the evidence and exhibits before the board. Therefore that is the evidence to be used in testing the validity of its action. Grady v. Katz (1938) 124 Conn. 525, 530.

The board made a finding of facts (Ex. 1), in conformity with the procedure recommended by the Supreme Court in Purdue v. Board of Zoning Appeals, supra, 179, and in Grady v. Katz, supra 530.

The charge (Ex. A) against the plaintiff (in the language found in the second and thrd clauses of grounds for action listed in section 2741 of the general statutes as amended by section 475f of the cumulative supplement thereto) was made by the Commissioner of Health, and alleged that in October 1945 the plaintiff "did medically treat one Norman Dombris, of Waterbury . . . in a fraudulent, dishonorable, unprofessional and incompetent manner."

The plaintiff points to the fact that there was no expert testimony before the board, and argues from this that there was no evidence before the board from which it could find malpractice. This might very likely be true if the board were a lay board, except in a case of the grossest nature. Chubb v. Holmes (1930) 111 Conn. 482, 486. Where the trier is a lay tribunal, it is usually necessary to present expert opinion evidence on any issue involving the technical care, skill and methods used by a physician in the treatment of a patient. Britton v. Hartshorn (1931) 113 Conn. 484, 493.

But this was not a case of malpractice before a lay tribunal. On the contrary it was a statutory hearing before a statutory board composed of persons who may be presumed to have special learning in a specialized field. Each was presumably peritus virtute officii. State vs. Main (1897) 69 Conn. 123, 140. The court will not, of course, substitute its lay judgment alone, for that of the board on a technical matter in the board's own specialized field. Under these circumstances the burden to show that the action of this board was improper was a heavy one in so far as the question of medical care and skill in methods and treatment was concerned. Driscoll vs. Jewell Belting Co. (1921) 96 Conn. 295, 299, 300.

With respect to the board's finding (Ex. I) it cannot be said that there was not actual evidence from which even a lay board could reasonably find unprofessional treatment (#3) as set forth, and incompetence in the respects set forth in subdivision (b) of #4. See Sage-Allen Co., Inc. vs. Wheeler (1935) 119 Conn. 667, 679.

This is sufficent to support the action of the board, quite without regard to whether the findings in paragraphs 1, 2, 4a and 4c are or are not reasonable lay inferences from the testimony presented.

But in the case of a hearing before any administrative tribunal the personal knowledge of the members of the tribunal may be considered even though no transcript of the evidence can disclose the nature or extent of such personal knowledge. Mrowka et al. vs. Board of Zonng Appeals (1947) 134 Conn. This is especially true in the case of such a specialized tribunal as we had here, where the testimony of the patient was interpreted by medical men if not by experts. Sickmund vs. Conn. Co. (1937) 122 Conn. 375, 381.

When this is taken into consideration it is obvious that the court cannot find on its own lay knowledge, that no body of medical men could reasonably reach the conclusions which that board did, on the evi-

dence before it, nor that it violated any rules of law or acted illegally, arbitrarily, capriciously or in abuse of its discretion.

The plaintiff complains that if specialized knowledge of members of a board (necessarily outside the transcript) can be utilized in interpreting the testimony adduced before the board there is no way to secure a judicial review of the board's action, especially its inferences as to medical care and skill drawn from the evidence presented. The same argument might have been made in Mrowka vs. Board of Zoning Appeals, supra.

In such a case as this, in order to overthrow the findings of the board as to professional care and skill in methods and treatment it would be almost essential, practically speaking, to present expert medical witnesses as to the proper interpretation of the transcript. Kulak vs. Landers, Frary & Clark (1935) 120 Conn. 606, 608. The only testimony of such a character offered here was that of the plaintiff, and his testimony was in factual conflict with that of the patient. Only if the court could find that no medical man could reasonably have reached the conclusions arrived at by the board on the evidence before it, could the board's finding be reversed, in the absence of evidence before it, could the board's finding be reversed, in the absence of evidence pointing to misconduct on its part in acting illegally, arbitrarily, capriciously, or in abuse of its discretion. The appeal is dismissed.

King, J.

Dr. Canfield Awarded Legion of Merit

Norton Canfield, associate professor of otolaryngology at the Yale University School of Medicine, was recently awarded the Legion of Merit for outstanding wartime service as Army consultant in otolaryngology in the European Theater.

Dr. Canfield, formerly an Army Colonel, was presented with the medal by Colonel Lawrence B. Bixby, Yale professor of military science, at a ceremony at the New Haven Hospital.

The citation accompanying the award declared:

"Colonel Norton Canfield performed exceptionally meritorious service as senior consultant in otolaryngology to the chief surgeon, European Theater of Operations, from January 1943 to August 1945.

"Through his unusual abilities in his specialty, his initiative and foresight in planning, and his untiring efforts, he established and maintained standards for the surgical care of the ear, nose, and throat for United States Forces in the European Theater that have been unsurpassed in the United States Army.

"His conclusive researches for the relief of increased intratympanic pressure and the improvement of speech communication at high altitudes increased the effectiveness of air combat crews and contributed greatly to their morale."

Dr. Canfield received his medical degree from the University of Michigan in 1929, and came to the Yale University School of Medicine in 1933 as an instructor in otolaryngology, and as resident otolaryngologist of New Haven Hospital. In 1935 he was made assistant professor, and associate professor in 1938.

He is chief of otology for the Veterans Administration, associate surgeon at the Grace-New Haven Community Hospital, and a consultant to the Veterans Administration Hospital in Newington. He is a member of the Connecticut State Medical Society, the American Medical Association, the American Academy of Ophthalmology and Otolaryngology, the American Otological Society, and an honorary member of the American Speech Correction Association and the sections of otology and laryngology of the Royal Society of Medicine, London.

Ruling on Use of Colored Oleomargine

In a recent issue of *Connecticut Law Journal* appears a decision of the Assistant Attorney General on the processing by a hospital of oleomargarine to change its color. The opinion is addressed to Honorable Frederick H. Holbrook, Food and Drug Commissioner, in answer to a request from a business manager of a general hospital. This hospital is quoted as being able to save $9,000 annually if permitted to serve colored oleomargarine to its patients in place of butter. The Federal Law requires a $600 Federal license to add coloring to oleomargaine. This hospital believes under the law, both Federal and State, it can serve colored oleomargarine to its patients since it is not in the business of selling food and its charges are the same for a patient's room whether he eats food served or receives intravenous feedings of fluids.

In the reply the Assistant Attorney General calls attention to the fact that the Connecticut statute prohibits the sale as well as the manufacture of colored oleomargarine. By the definition in the fed-

ral statute it becomes apparent that one is a manufacturer of colored oleomargarine whether the coloring is done by him while the article is being produced or after the article was placed on the market.

The final decision:

(a) A hospital becomes a manufacturer by processing oleomargarine to change its color, and

(b) Colored oleomargarine may not be served by hospital in its hospital or cafeteria.

New Section on Aviation Medicine

On November 2, 1947 the organization was officially recognized, permission being granted by the council of the Society. The following is the general set-up:

PURPOSE

To keep the members of the Section informed on advances in medicine and its allied fields as applied to aeronautics.

MEMBERSHIP

A. Any member of the Connecticut State Medical Society who is actively engaged in the field of aeronautics.

B. Any member of the Connecticut State Medical Society who is a graduate of the Army or Navy School of Aviation Medicine but who may not at the present time be engaged in the field of aeronautics.

C. Any member of the Society who may be engaged in research or teaching in those fields which have a direct bearing on aviation medicine.

OFFICERS

A chairman and a secretary.

COMMITTEES

There shall be one standing committee composed of five members. These members shall be appointed to represent several classifications. The chairman of the Section will be the chairman of the committee. One member will represent the field of regulation. Another member will represent industry and scheduled operations. The fourth will represent research and teaching and the fifth member will represent that group of the Section members who are graduates of the military schools of aviation medicine. The secretary of the Section will be a member ex officio and will record the minutes of the meetings.

DUES

It is not contemplated at this writing that there shall be any set dues. The expenses of the Section for a current year will be prorated among the members.

MEETINGS

It is contemplated that there will be two meetings of the Section yearly. These will be held at the time of the annual meeting of the Connecticut State Medical Society and at the fall meeting of that Society better known as the Clinical Congress.

The purpose of the Section as stated above will really be two-fold. Through the meetings and speakers it is hoped that the latest information in the field of aviation medicine may be brought to the members of the Section. As this is accomplished the Section's important purpose will become an accomplished fact: namely, the Connecticut State Medical Society will be in a position at any time to advise or take under consideration any problems in civil aeronautics which may be presented to the Section.

Finally, at this writing there are approximately 28 members and so far as can be determined a membership of 60 is possible. James W. Crane of Springdale is chairman.

New Clinic For Alcoholics

A group of representative citizens, including doctors, nurses, clergymen, and laymen from various towns in Fairfield County, has decided to establish, in cooperation with the Connecticut Commission on Alcoholism, a clinic for alcoholics in the County.

Meeting at the auditorium of the Connecticut Power Co., the group discussed the need for a third clinic in the State, to be located in this area. Bridgeport and Stamford were mentioned as possible sites for location of the proposed clinic. Such clinics are already established in Hartford and New Haven, and there is a possibility that Stamford may be chosen for the site because of its central location. However, discussion also proved that Bridgeport is a likely place for a clinic because of the larger population.

A steering committee was apponted to formulate plans for the establishment of the clinic, and will have further meetings to report progress on its study. Members are: L. T. Bolger, Stamford; Northrop Dawson, New Canaan; Mrs. Malcolm Edgerton, Stamford; John T. Fleming, Bridgeport;

Samuel J. Keeler, Norwalk; Mrs. Anthony V. Lynch, Jr., Greenwich; Dr. Harry M. Tiebout, Greenwich, and Cornelius Utz, Bridgeport.

Dr. Harry M. Tiebout, psychiatrist, of Greenwich, chairman of the advisory committee of the National Committee for Education on Alcoholism, cited this "illness" as the fourth major health problem in the country. He declared that there are some 700,000 alcoholics in the country and the number of people who drink to excess in the country totals some three million.

Dr. Seldon D. Bacon, chairman of the Connecticut Commission on Alcoholism, and secretary of the NCEA, spoke on the problems faced by alcoholics. All individuals demand different treatment, he stated. Using the city of Bridgeport as an example to illustrate the increasing number of cases in this part of the State, Dr. Bacon quoted figures from statistics which show that there are from 900 to 1,000 chronic alcoholics in that city and from 2,500 to 3,000 chronic alcoholics and drinkers combined.

"The alcoholic presents a series of problems," Dr. Bacon declared. "There is the problem of the individual alcoholic, his family, the community at large, his job, the loss faced by his employer, and many others," he said. Dr. Bacon's figure on the number of chronic alcoholics in the country was about four million, most of them men from the ages of 30 to 50.

Dr. Bacon declared that outpatient clinics try to return the alcoholic to a way of life without alcohol, in a way in which he feels satisfied with himself, and the community is satisfied with him. A minimum of $25,000 has been set aside by the State for an outpatient clinic he stated.

Child Psychiatry Institute Started

Construction has been started on the campus of the Institute of Living in Hartford of an Institute of Child Psychiatry, which will be unique in the psychiatric world. Ground was broken for the new structure on January 31, and the contract calls for delivery of the building in August of this year.

The Institute of Child Psychiatry will be a five-story structure, with an ultimate capacity of 66 children of adolescent and preadolescent age.

Cost of the project is estimated at more than $150,000, of which over $100,000 already has been subscribed. A large part of this sum has come in donations varying from fifty cents to a few dollars. The response, states the Institute, has been most inspiring. Many contributions have come from members of the Institute's own personnel in the form of small savings. The donations include a gift of garments to be worn by the future small guests at the Child Psychiatry Institute.

For over 15 years the Institute of Living has been experimenting in a small way with treatment of children. The results have proved so successful and encouraging that nationwide attention has been aroused. Psychiatric leaders urged the Institute to undertake construction of the new building, which will be devoted exclusively to care of children.

Despite high construction costs, the Board of Directors of the Institute decided the need for the new undertaking is urgent and the project should be started at once. Coincident with announcement of the start of construction, the directors appealed to the public to aid in raising the $49,000 needed to complete the structure. The directors expressed confidence that public spirited citizens will respond and aid this pioneering effort. Outstanding psychiatrists long have recognized the need for such a child psychiatry unit and have said that treatment of psychiatric disturbances in childhood is the only certain preventive psychiatry in a majority of cases.

The Institute of Living is to have a "Parentorium" in conjunction with the Child Psychiatry Institute. The "Parentorium" idea, a move aimed at parent guidance, originated at the Institute.

The new Child Psychiatry Institute will contain classrooms, a gymnasium, shops, treatment rooms and all other facilities that are needed in handling a group of children for whom there has been to date no provision in this country. The existing extensive facilities and therapies of the Institute of Living will be made available to the children.

A. F. Peaslee, Inc., the low bidder, is the general contractor. The architect is Irving W. Rutherford.

Connecticut Blue Cross Opens Direct Enrollment in New Haven and Norwalk

Connecticut Blue Cross opened membership on a community-wide basis February 1 to an estimated 65,000 people who have been unable before now to join the non profit hospital plan.

Acting with approval of the State Department of Insurance, Blue Cross offered for the first time in its history full member-benefits without physical exam-

ition to all persons in the New Haven-Norwalk a who are under age 65 and not eligible to join rough a place of employment. Previously, enrollent was possible only through payroll groups of e or more persons.

Direct enrollment application blanks will be availle at Blue Cross offices. By simply mailing these anks to Blue Cross headquarters, applicants may roll themselves in the plan. There will be no perinal solicitation during the campaign.

This first direct enrollment opportunity was nited to people living in Greater New Haven and orwalk, where Blue Cross was born eleven years o. Blue Cross hopes to offer direct enrollment for nilar two-week periods in all communities in Conecticut by the end of 1948.

Benefits under direct enrollment will be exactly e same as those held by group members. These clude 21 days of care in any of the 33 general ember hospitals in Connecticut, with all special rvices provided, regardless of amount, plus a credit \$6 per day for room, meals and general nursing rvice. Cash credits are made for maternity care d out-of-state hospitalization.

Monthly membership dues under direct enrollent are \$1.34 for individuals, \$2.67 for husband d wife, and \$3.17 for families, including husband, ife and all unmarried children under age 19. These e slightly higher than group rates, and are the me as paid by present direct-pay subscribers who ave left the employ of their particpating firms.



The New Journal "Cancer"

The first issue of *Cancer*, a new journal to be sponsored by the American Cancer Society, will soon be published, according to a recent announcement.

Editor of the journal will be Dr. Fred W. Stewart, of New York City. Paul B. Hoeber, Inc., an affiliate of Harper and Brothers, has been selected as the publisher.

Cancer will publish original papers for those concerned with any phase of the cancer problem—surgeons, internists, radiologists, those interested in public health, statistics and education, and cancer experimentalists.

While two important cancer journals already exist, these are largely devoted to reports of experimental laboratory research. Clinical papers on cancer are today scattered among numberless journals whose interests are considerably broader, and thus significant material is often lost to the main stream of cancer progress.

Cancer proposes to fill the need for a periodical devoted exclusively to cancer, with major emphasis on clinical reports and significant experimental studies. In addition to original papers, an important feature of the new journal will be its abstract department. This will include a complete current bibliography of the world's scattered literature on the subject, as well as carefully prepared abstracts of all significant papers.

The journal will contain no paid advertising, and will be liberally illustrated. Its subscription price has been announced at \$8 per year. The editors plan to publish acceptable papers more promptly than usual, and authors will be allowed 200 free reprints. Original papers submitted for consideration should be addressed to the Editor, 444 East Sixty-Eighth Street, New York 21, New York.

Reservations for

A.M.A. Annual Session

in Chicago June 21-25

should be made now

Committee on Public Policy and Legislation
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Richard H. Grant, Cromwell
New London County, Edmund L. Douglass, *Chairman* Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, Leonard W. Levine, Ellington
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIR

NEWS FROM WASHINGTON

The President Intent on National Compulsory Health Insurance

In his budget message of January 12 President Truman went all out for national compulsory sickness insurance. He proposes to appropriate $15 million to inaugurate the program. Also he proposes to start collecting increased social security taxes in the fiscal year 1949. He expects payroll deductions to yield $150 million for the medical care insurance fund the first year.

Finance Security Agency Going to Town

In 1946 arguments were advanced that if the Federal Security Agency were reorganized under the No. 2 plan of the President savings would result. Now the President recommends that FSA appropriations be increased in 1949 by $98 million over the 1947 expenditures, an increase of 70 per cent. He also recommends increasing appropriations for the present programs of FSA from $140 million to $222 million and of starting the ball rolling for compulsory medical care with $15 million for setting up the administrative machinery. All told, the President proposes to increase expenditures for social welfare, health, and security by 50 per cent between 1947 and 1949.

Senator Ball Speaks

Mr. Joseph H. Ball, distinguished Republican Senator from Minnesota, has earned a brilliant reputation as a keen student of political science and a champion of what is best called "the American way of life" since he entered the United States Senate in 1940 at the age of thirty-four.

Senator Ball is one of the co-authors of the Taft National Health bill, S145, which has received the support of most segments of organized medicine. His political philosophy is of more than passin interest to the medical profession.

In an address delivered in Chicago last Novembe Senator Ball fearlessly set forth his views on th trend toward socialism or collectivism in Americ

Pointing out that socialism in England is no dif ferent from the brand being advocated in the Unite States, Senator Ball said, "I earnestly hope that seein England resort to drafting men, telling them fo whom and for what they must work or starve wil wake up some of our people in America, who hav been supporting various socialistic schemes an planned economy programs in the belief that the could have a government do everything for every body without having it also tell everybody wha they must and cannot do.

"I have deliberately used socialism and a planne economy as synonymous because they are the sam thing in reality. The socialists aim at governmen ownership and operation of all production and dis tribution. The planned economy advocates woul leave ownership technically in private hands, bu have the government bureaus granted power t dictate every detail of operation. Either system add up to government dictation, one by the Nazi pat tern, and the other by the communist pattern.

"Typical of the kind of proposals supported by both groups are the Wagner-Murray-Dingle bill t socialize medicine and make health insurance com pulsory for all of us."

92 Projects Approved Under Hill Burton Act

As of January 9, according to Public Health Serv ice, 92 applications for constructon of hospitals dispensaries and health centers under the Hill-Bur ton Hospital Survey and Construction Act had beer

approved. Total estimated cost is $40,765,702, of which $13,381,548 would be the Federal share. States represented in the list are Alabama, Florida, Illinois, Indiana, Kentucky, Mississippi, New Mexico, North Carolina, Oklahoma and Texas. Practically all of the projects are planned for rural areas.

New Research Hospital

The national budget for 1948-49 submitted to Congress by President Truman includes a $5,000,000 item to start construction on the 500-bed research hospital which is to be built on the National Institute of Health reservation at suburban Bethesda. Total estimated cost is $34,000,000. But meanwhile the grandiose scheme for a huge Army Medical Center at Forest Glen, Md., which Corps of Engineers prematurely announced last spring is a dead pigeon. If and when Army Institute of Pathology gets a new home, it will be erected not at Forest Glen but on Walter Reed Hospital grounds. Likewise any new structure for Army Medical Library—whose possibility seems just as remote—will probably have its site adjacent to Library of Congress annex on Capitol Hill, rather than at Forest Glen.

Committee on Medical and Hospital Services of the Armed Forces

The Secretary of Defense has appointed an interdepartmental committee, consisting of Dr. Paul R. Hawley, chairman; Rear Admiral C. A. Swanson, Surgeon General of the Navy; Major R. W. Bliss, Surgeon General of the Army; and Major General Malcolm C. Grow, the Air Surgeon, to make "a thorough, objective, and impartial study of the medical services of the Armed Forces, with a view to attaining, at the earliest possible date, the maximum degree of coordination, efficiency and economy in the operation of these services." Rear Admiral Joel T. Boone has been called to Washington to act as executive secretary of the committee.

Dr. Marjorie Shearon Testifies Before Congress

It is argued that medical services being too expensive to be paid for by the persons receiving the services, the burden is to be dumped on the doctors who are ordered to assume a major portion of the expense. They are told they must give all patients all the care they need for a flat sum of $5 or $6 a year. They would be put completely at the mercy of neurotics and of chronic patients whose large demands would not, however, entitle a doctor to receive any extra pay. *I do not know of any other case in which services are performed either by trades or by professions in which there is no relation between the amount of pay received and the service performed.* Organized labor would not agree to any such arrangement of payment for its own services. Yet this is what would be done to the medical, dental, and related professions under a capitation system. This is what is meant by regimentation of patients and practitioners.

The whole philosophy underlying compulsory sickness insurance is one of regulative control. There are rules for patients, for physicians, for nurses, pharmacists, hospitals, etc. Primary emphasis is placed on protection of the insurance funds, not of the patient. Everyone involved in the system—and under the proposals now before Congress, that would be everyone in the United States—would be compelled to be subservient to the Federal officials who would police the system or to the local representatives of governmental authority who in turn would be nothing more than remotely controlled proxies acting as "peripheral contacts" for the Federal Government.

RECOMMENDS JOINT CONGRESSIONAL COMMITTEE ON SOCIAL SECURITY

In her testimony before the Health Subcommittee of the Senate Committee on Labor and Public Welfare Dr. Marjorie Shearon recommended the creation of a Joint Congressional Committee on Social Security. The first duty of such a committee would be "to study the desirability of repealing the Social Security Act before the Nation is entirely engulfed by the legislative program which is being promoted."

Dr. Shearon believes we are headed straight for State Socialism and dictatorship via a comprehensive scheme of National Compulsory Social Security for the entire population. It will be tax, and tax, and tax. It will be rule, regulate, and regiment.

New Bills Introduced

HR4949 by Mr. Kearney of New York, January 14. A bill to provide *hospitalization and pensions to veterans* of certain campaigns on a parity with

war veterans.

Referred to the Committee on Veterans' Affairs.

Comment: The measure was introduced by request and seeks to amend the Veterans Regulation, providing *hospitalization for persons* who participated as members of the active military or naval forces in any campaign since the Spanish-American War and prior to World War II.

HR5037 by Mr. McCormack, of Massachusetts, January 20. A bill to exempt from the manufacturers' *excise taxes articles sold to hospitals* not organized for profit.

Referred to the Committee on Ways and Means.

Comment: The Internal Revenue Code is to be amended to provide exemption from manufacturers' excise taxes certain articles sold to hospitals not organized for profit.

HR5087 by Mr. Keefe, of Wisconsin, January 21. A bill to provide for *research and control relating to diseases of the heart* and circulation.

Referred to the Committee on Interstate and Foreign Commerce.

Comment: This measure provides for the development of a National Heart Institute, patterned after the National Cancer Institute, for the purpose of research, investigations, experiments, and demonstrations relating to the cause, prevention, methods of diagnosis, and treatment of heart diseases. In carrying out the purposes of this Act, the Surgeon General of the Service is authorized to: (1) make grants-in-aid to universities, hospitals, laboratories, and other public or private agencies and institutions, and to individuals for research, education, and control projects and programs; (2) establish an information center on research, prevention, diagnosis, and treatment of heart diseases; (3) establish and maintain from funds appropriated or donated for the purpose, research fellowships in the Institute and elsewhere with such stipends and allowances as he may deem necessary to train research workers and procure the assistance of the most brilliant and promising research fellows from the United States and abroad; (4) establish and maintain from funds appropriated or donated for the purpose of traineeships, in the Institute and elsewhere in matters relating to the diagnosis, prevention, and treatment of heart diseases with such stipends and allowances as he may deem necessary to train persons found by him to have proper qualifications; (5) for purposes of study, admit and treat at the Institute voluntary patients suffering from heart diseases. There is created a National Heart Council, to consist of the Surgeon General, the chief medical officer of the Veterans' Administration, the Surgeon General of the Army, the Surgeon General of the Navy, and twelve members appointed without regard to the civil-service laws by the Surgeon General with the approval of the Federal Security Administrator. The amount to be appropriated for carrying out the purposes of the Act is to be left entirely up to Congress. Mr. Keefe feels that this sum should be based on necessity, availability of funds, and the judicial expenditure of such funds as may be appropriated for this purpose.

HR5159 by Mr. Smathers, of Florida, January 27. A bill to provide for *research relating to diseases of the heart* and circulation, including high blood pressure, in a supreme endeavor to develop speedily more effective methods of prevention, diagnosis, and treatment of such diseases, and for other purposes.

Referred to the Committee on Interstate and Foreign Commerce.

Comment: This bill is almost identical with HR5087.

Action on Bills

S1454 and HR3924—Companion bills submitted by the United States Public Health Service, providing for its reorganization to make it accord with the Army organization.

The Senate bill was amended on the floor by adding a section which would permit osteopaths to establish eligibility for classification as medical officers. The Public Health Service felt that there is such necessity for the enactment of the bill that it could not afford to lose it because of the amendment; but, in the House of Representatives, at the request of Congressman Judd and Congressman Smith of Ohio, the bill has been laid aside for two weeks.

S140 was reached again on the Senate Calendar and laid aside at the request of Senator Byrd (D), of Virginia.

Social Security Advisory Council

The 17-member council, under the chairmanship of Edward R. Stettinius, met January 16 and 17, to consider broadening of the Social Security Act to

cover the eight groups not protected at the present ime, or coming under other systems, and for the consideration of proposals for paying larger benefits. This council is the third group of citizens which had been appointed to frame proposals for the Department of Social Security. The meeting was attended by Sumner A. Slichter, professor of economics at Harvard University, and associate chairman of the council, who presided over the meeting.

Veterans Advanced Professional Training Program

Dr. Walter Martin is one of a pair of civilian Army Medical Consultants selected to participate in a new Veterans Advanced Professional Training Program. He departed the 29th of January for a one-month tour of Army hospitals in the American Occupied Zone of Germany. The team is to study and report on means of improving the care of hospital patients and to act as instructors in specialized advanced training of Army hospital staff officers. Other teams will be selected to succeed this, at monthly intervals.

New Members-National Advisory Cancer Council

The Federal Security Administrator announced the appointment of Dr. Edward R. Doisy, of the St. Louis University School of Medicine and a Nobel Prize winner in Medicine in 1943; and Dr. John J. Morton, Jr., of the University of Rochester (New York) School of Medicine and Dentistry; as members of the National Advisory Cancer Council of the National Cancer Institute. Dr. Doisy gained world-wide eminence through his discovery of *theelin*, and isolation and synthesis of vitamin K. Dr. Morton was a former president of the American Cancer Society, and is now a member of the Committee on Growth, of the National Research Council.

Providence Medical Association Centennial

On March 6, 1848 the first annual meeting of the Providence Medical Association was held in Providence, Rhode Island. This meeting had been preceeded by three others within a period of five weeks at which a constitution and by-laws and also a fee table were adopted. The first scientific meeting of the new association occurred on May 1, 1848 when clinical material was presented by Dr. H. W. Rivers. In 1899 the *Providence Medical Journal* was established, continuing publication bi-monthly until its purchase in 1917 by the Rhode Island Medical Society.

The January 1948 issue of the *Rhode Island Medical Journal* features the Providence Association's centennial. In addition to an excellent historical survey of the Association's one hundred years, that *Journal* prints the minutes of the first meetings of the Providence Medical Association. Copies of announcements concerning public vaccination, the Rhode Island Medical School, and the preservation of the dead (by two physicians) also are included. A short sketch of "Providence in 1848," a city of 40,000 people, informs the reader that George Thurber was "Inspector of Saleratus and Bi-Carbonate of Soda," and that gas lamps were being installed in place of the former naphtha lamps. The Centennial Issue contains many illustrations of early buildings and individuals of importance in the annals of Providence medicine.

Just two years earlier the physicians of Hartford, Connecticut, organized the Hartford Medical Society. In 1946 this group likewise celebrated its centenary, indicating that organized medicine, at least in some of our New England cities, is entering upon another hundred year cycle.

OUR NEIGHBORS

New Jersey

The Board of Trustees of the Medical Society of New Jersey has formally approved cooperating with Radio Providence Productions in extending the program "Doctor's Orders" throughout the State of New Jersey. This same program is now in operation in several other states. A five minute medical talk is broadcasted weekly by some physician over each station where arrangements for presenting the program have been made.

New York

The International Brotherhood of Electrical Workers, A. F. of L., in greater New York is backing a drive for funds for the Institute of Rehabilitation at New York University, College of Medicine. Such an endorsement is almost without precedent.

The drive for $7,500,000 for the Medical Center fund in New York City fell short by about $1,000,000 at the end of the campaign on December 31, 1947. Mr. John D. Rockefeller, Jr., who had promised a second $500,000 if the campaign attained its objective, is reported to be reconsidering the matter.

THE DOCTOR'S OFFICE

Morton Arnold, M.D., announces the removal of his office for the practice of eye, ear, nose and throat from the Windham National Bank Building to 29 North Street, Willimantic.

Robert Desmond Baird, M.D., announces the opening of an office for the practice of internal medicine at Twin Pines Convalescent Home, Northville.

Fred C. Collier, M.D., announces the opening of an office for the general practice of medicine in the Windham National Bank Building, Willimantic.

Joseph E. Daly, M.D., announces the opening of an office for the general practice of medicine at 20 East Main Street, Waterbury.

William A. Ellis, M.D., announces the opening of an office for the practice of general surgery and chest surgery at 945 Asylum Avenue, Hartford.

Charles H. Hamlin, M.D., announces the opening of his office for the practice of obstetrics and gynecology at 945 Asylum Aveune, Hartford.

Clarence W. Harwood, M.D., announces the opening of an office for the practice of pediatrics at 111 College Street, Middletown.

Kathryn Huss, M.D., announces her association with J. Alfred Wilson, M.D., William C. Carey, M.D., John H. Huss, M.D., Francis Giuffrida, M.D., and John B. Flynn, M.D., in the general practice of medicine at 118 Colony Street, Meriden.

Louis Langman, M.D., announces the opening of an office at 83 Orchard Street, Cos Cob.

B. E. Lyons, M.D., announces the opening of an office for the practice of ophthalmology in the Bishop Building at 64 Wall Street, Norwalk.

Richard J. Ohman, M.D., announces the opening of an office for the general practice of medicine and surgery at 707 Watertown Avenue, Waterbury.

Lee Jay Whittles, M.D., announces the reopening of his offices for the practice of internal medicine and pediatrics at 2205 Main Street, Glastonbury.

Charles C. Yerbury, M.D., announces the opening of an office for the general practice of medicine at 1070 Enfield Street, Enfield.

Breast Milk Best For Infants

As a food, human milk still remains the best type of milk for young infants, according to a survey by a subcommittee of the Committee on Maternal and Child Feeding of the National Research Council published in the December 6 issue of *The Journal of the American Medical Association*. C. Anderson Aldrich, M.D., Rochester, Minn., is author of the published report.

"Breast milk is to an appreciable extent a prophylactic food; it prevents or decreases the severity of many gastrointestinal disturbances," Dr. Aldrich writes, adding that it is an absolute preventive against constipation because it cannot solidify in the intestinal tract. "This preventive role of breast milk is much more noticeable when it operates among children in the less favored economic classes, among whom adequate health measures are not always available," he continues. In many of these gastrointestinal disturbances no other food seems adequate or assimilable. For this reason he suggests that breast-milk stations be made available in large city areas.

One of the chief objections to breast-feeding, Dr. Aldrich observes, is that it sometimes causes infections of the breast. With the advent of chemotherapeutic agents such as sulfa and penicillin, this danger has somewhat lessened. Another objection is that breast milk may be too small in quantity to nourish the baby adequately. "When this is true, even after a conscientious attempt has been made, complemental feedings should be given after the breast feeding," the writer states. "However, it is believed that the diagnosis of insufficient breast milk is made too often on scanty evidence. . . .

"It has been stated that in this enlightened age breast feeding is unnecessary and a burden which the mother need not be expected to assume. This may be true in the case of babies whose care is under the direction of skilled physicians, but it probably is not true for the great number of babies reared under conditions in which competent medical advice is inadequate or unavailable."

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

VA Speakers Bureau in Hartford

A speakers bureau designed to provide service rganizations, private, civic and professional groups ith speakers on veterans affairs and legislation has een organized at the Hartford Veterans Adminis- ation Regional Office, Harry T. Wood, manager, nnounced recently.

"Because the Veterans Administration adminis- rs the bulk of legislation pertaining to veterans' enefits," Wood said, "members of our staff are ell qualified to talk on such benefits as medical care nd treatment, compensation and pensions, loan uaranty, dependents' benefits, education and train- g, hospitalization rehabilitation and insurance.

"We offer the services of these experts to those roups and organizations who should like to sched- le a speaker on veterans' affairs."

VA speakers may be obtained by contacting E. . Spencer, Jr., Veterans Administration, 95 Pearl treet, Hartford.

Dr. Paul Magnuson New VA Medical Director

Paul B. Magnuson, nationally known orthopedic urgeon and closely identified with the reorganiza- ion of medical care in Veterans Administration ospitals, on January 14 was named chief medical irector for VA by Carl R. Gray, Jr., administrator. n announcing the appointment, General Gray ointed out that this will assure an uninterrupted ontinuation of the medical program of the Veter- ns Administration which was inaugurated under Dr. Hawley.

Dr. Magnuson, former professor of surgery and hairman of the Department of Bone and Joint urgery at Northwestern University Medical chool, Chicago, succeeds Dr. Paul R. Hawley, who esigned January 1 as medical chief and who now is erving Mr. Gray as special assistant and advisor n medical problems.

Dr. Magnuson, a native of St. Paul, Minn., has been intimately associated with VA's Department of Medicine and Surgery since its inception January 3, 1945. During that time he has been closely associated with Dr. Hawley in reorganizing VA's medical program. Working with Dr. Hawley, Dr. Magnuson played a large role in affiliating more than half of VA's 126 hospitals with Class "A" medical school over the country and in the establishment of VA's residency training program.

Dr. Magnuson's first position with VA was as chief of the Research and Education unit. In this position he launched and completed the residency training program and also aided in starting a comprehensive research program into many of the little known ailments and diseases suffered by veterans.

On September 19, 1947 he was appointed acting chief of Professional Services, a position he has served in since.

As chief medical director, Dr. Magnuson will continue to work closely with Dr. Hawley. Dr. Hawley, as special assistant and advisor to Mr. Gray, will continue to assist in carrying out the medical program and the continued association of these two nationally famous doctors will insure that there will be no change or delay in the VA medical program.

Dr. Magnuson Begins With Strong Language

Shortly after Paul B. Magnuson took office as chief medical director of the Veterans Administration in Washington, he issued a statement to the press in which he said he was going "to clean out the skunks and chislers" who overcharge GI's for medical service. The *Chicago Tribune's* lengthy story about Magnuson's statement was headlined: "Oust Skunks, Says New VA Medical Head." Thereupon, the Council of the Illinois State Medical Society adopted a resolution, protesting against Magnuson's

language. The council said his reference to "skunks and chislers is intemperate and gives an unwarranted false impression."

VA "1948 Program" of Hospital Construction

Bids on a proposed new hospital at Saginaw, Mich., will be opened March 16. Plans are available for contractors. This will be a 200-bed general medical and surgical hospital.

Bids on the construction of a 564-bed addition to the neuro-psychiatric hospital at Lebanon, Pa., were opened February 10, and on a 150-bed addition for tuberculosis patients at the VA hospital in Portland, Ore., February 24.

Hospitals in the "1948 program" to be designed and constructed by VA architects and engineers, as approved by Congress in July 1947, include the following:

Boston, Mass., 1,000-bed neuropsychiatric.

New York area, 1,000-bed general medical and surgical.

North Carolina area, 1,000-bed neuropsychiatric.

Memphis, Tenn., 1,000-bed neuropsychiatric.

Ann Arbor, Mich., 500-bed general medical and surgical.

Cleveland, Ohio, 1,000-bed general medical and surgical, and 1,250-bed neuropsychiatric.

Chicago, Ill., 1,000-bed general medical and surgical.

Topeka, Kan., 1,000-bed neuropsychiatric.

Oklahoma City, Okla., 1,000-bed general medical and surgical.

Marlin, Tex., 200-bed general medical and surgical.

Los Angeles, Calif., 1,000-bed neuropsychiatric.

San Diego, Calif., 200-bed general medical and surgical.

San Francisco, Calif., bay area, 1,000-bed neuropsychiatric.

Denver, Colo., 500-bed general medical and surgical.

An addition of 250 T.B. beds at Albuquerque, N. M.

Two other hospitals, approved prior to July 1947 also will be desgined by VA architects. These hospitals are for Atlanta, Ga., 750-bed general medical and surgical, and Indianapolis, Ind., 500-bed general medical and surgical.

VA's Construction Service in recent weeks has awarded contracts on two large additions to existing hospitals. One of these is a 119-bed addition for tuberculosis patients in the VA hospital at Livermore, Calif., and the other is a 130-bed project, also for tuberculosis patients, at San Fernando, Calif. Both of these projects were awarded to contractors two days after bids were opened.

Plans for the 500-bed general medical and surgical hospital at Denver, Colo., are in the working drawing stage. No date for opening of bids has been set.

Plans are being completed for a 250-bed tuberculosis addition to the present VA hospital at Alexandria, La., but no date has been set for advertising for bids.

Scheduled for advertising for bids in the near future is the 200-bed general medical and surgical hospital at Marlin, Tex. Working drawings for this hospital are nearing completion. No date has been set for opening of bids.

Eighty-nine new hospitals remain to be completed in the 1947-1948 construction program. All are either on drafting boards, under contract or under construction.

Rules For Veteran Training Courses

The Veterans Administration has ruled that World War II veterans are ineligible for training under the GI Bill or the Vocational Rehabilitation Act (Public Law 16) while they are taking training in certain courses financed by other federal appropriations.

The ruling held that training and education provided by the two veterans' training laws was not intended to duplicate training of veterans already enrolled in courses of study and receiving benefits for training from other United States Government appropriations.

Accordingly, veterans must select the Federal program under which they prefer to enter certain types of training.

VA said that certain courses financed by Federal appropriations are available to veterans as well as to other persons. These are separate from the training programs established for eligible veterans under Public Law 16 and the GI Bill (Public Law 346).

mong such courses are:

(1) U. S. Public Health training programs for rsons receiving fellowships or salaries from state d other grant-in-aid funds derived wholly or in rt from Federal appropriations.

(2) U. S. Maritime Commission training pro-ams.

(3) Resident training programs in hospitals, nics, medical or dental laboratories owned or erated by the U. S. Government.

(4) Residency training for physicians and dentists the Department of Medicine and Surgery of the terans Administration.

The restrictions do not apply to veterans enrolled der either law in VA's training program for nical psychologists. These trainees may receive sistence allowances based on the training pro-ded them in educational institutions. They may paid from Government funds for part time work VA stations where neuro-psychiatric veterans are ated.

The ruling will not affect veterans training on-e-job under either law in those Federal agencies d establishments approved by VA to offer such ining.

VA said the instruction does not eliminate pos-le concurrent payment of benefits for study in a reign institution under both the GI Bill and the lbright Act (Public Law 584, 79th Congress).

When veterans complete their training under her Federally supported programs, they become gible to continue their studies or take other train-g under provisions of the GI Bill or Public Law .

Osteopaths Included

Osteopathic physicians now are authorized to ovide outpatient treatment within certain limits to terans with service-connected disabilities, Dr. ul B. Magnuson, chief medical director of Veter-s Adminstration, said recently.

"Within the limits of practice of the healing art posed by their respective state licenses, osteo-thic physicians, when their services are requested veterans, may be designated to provide outpatient eatment, on a fee basis, for service connected dis-bilities under the same rules and regulations as vern such services by doctors of medicine," Dr. lagnuson stated.

Public Law 293, 79th Congress, authorizes VA to hire doctors of osteopathy to work with veterans.

All treatment given by doctors of osteopathy or doctors of medicine under the "home town" medical care program must have prior approval of VA.

Dr. Carniglia's 44th Birthday

Ettore F. Carniglia, hard working and dependable family physician of Windsor Locks, received a gift from patients and friends on January 8 which he will long remember. Putting on his hat and coat and grabbing his medical bag, he hurried out his back door to get into his old Cadillac coupe. The car had registered more than 100,000 miles. He found instead a new model coupe of the same make with a card fastened to the steering wheel. It read "Happy Birthday, Doc—Your Windsor Locks Friends."

Dr. Carniglia exemplifies the true family physician of which so much has been said and written of late. Covering not only his own town, he has served the surrounding towns in the northern section of Hartford County when other physicians have been unavailable. Day and night, winter and summer, the past 15 years have found him doing his stint as a general practitioner, with little thought for himself. The folk of Windsor Locks realize their good fortune and their expression of appreciation is timely.

Technical Director of Blood Program Chosen

Appointment of Dr. Louis K. Diamond, hematologist and assistant professor of pediatrics at Harvard, as technical director of the National Blood Program was announced recently by American Red Cross. At the time, Dr. Ross T. McIntire, administrator of the project, was in Stockton, Calif., for the opening of the newest member in the $10,000,000 donor center chain which will be established this year. His chief deputy, Dr. George B. Dowling, went to Atlanta to participate in a symposium on blood sponsored by Fulton County Medical Society preliminary to inauguration of a donor center in the Georgia capital. Also on the Atlanta program was Capt. Lloyd R. Newhouser, the Navy's leading authority on blood substitutes and fractionation.

New Experimental Biology and Medicine Institute

Establishment of an Experimental Biology and Medicine Institute, in the National Institute of Health of the U. S. Public Health Service, has been announced by Oscar R. Ewing, Federal Security Administrator. The new research institute will combine the functions of the Division of Physiology and the Pathology and Chemistry Laboratories and will permit greater coordination of scientific investigations.

Dr. William Henry Sebrell, Jr., chief of the Division of Physiology, has been named director of the new Institute. He will also serve as associate director of the National Institute of Health.

Formation of the Institute is part of a wider organization of the National Institute of Health, Thomas Parran, Surgeon General of the Public Health Service, explained. Four other divisions and laboratories engaged in scientific research also will be consolidated into two additional institutes. All of them will be modeled after the National Cancer Institute.

The director of the new Institute is an authority in the field of nutrition who has been with Public Health Service since his graduation from the Virginia School of Medicine in 1925. He served under Dr. Joseph Goldberger, pioneer nutritionist, and after Dr. Goldberger's death in 1929, was placed in charge of nutrition studies at the Institute. In 1940 he received the Mead Johnson Award of the American Institute of Nutrition, for research on vitamin B complex and in 1946 was awarded the research medal of the Southern Medical Association.

In 1945, at the request of the War Department, Dr. Sebrell spent three months in Europe as consultant on nutrition to the U. S. Army's Military Government Public Health staff. For his outstanding services he was awarded the Legion of Merit, which was presented to him March 29, 1946. On subsequent temporary duty with the War Department, he accompanied ex-President Herbert Hoover on his trip to Germany to examine health conditions.

Dr. Sebrell is an honorary member of the Harvey Society, a Fellow of the American College of Physicians, and of the American Public Health Association, an Associate Fellow of the American Academy of Pediatrics and a member of the Food and Nutrition Board of the National Research Council.

Health Education

A preview of the fourth edition of "Health Edu cation," published since 1924 by the Americ Medical Association and the National Educatio Association for guidance of educators in teachin health subjects, was given recently by Charles Wilson, M.D., editor-in-chief, and professor of edu cation and public health at Yale University Scho of Medicine.

In an interview Dr. Wilson said that materi suitable for college and adult education classes wi be included in the 400-page volume this year fo the first time. Previous editions have been limite to material for elementary and secondary scho groups. The new edition will also include a large fund of information concerning the use of audi and visual aids for the teaching of health subjects.

Chapters for the publication have been writte by 20 medical and educational authorities through out the country, reviewed by 45 consultants, an are now in the hands of the editorial committee fo final revision, Dr. Wilson said. He stated that th end result "will be a completely new report, de signed to furnish the best possible aid to teache responsible for instruction in health subjects."

The 17 chapter volumes will be published i November, following presentation before the Join Committee on Health Problems in Education of th Amreican Medical Association and the Nationa Education Association at a meeting to be held i Chicago early in May.

Chapter headings will include: Health Educatio and Children; Psychology of Health Teaching Health Education in the College; Adult Healt Education; Secondary School Health Education, an 12 other chapters on similar subjects.

Philadelphia To Have Diagnostic Pay Clinic

Pennsylvania Hospital has opened a diagnosti clinic for private patients with a per capita regis tration fee of $100. The Benjamin Franklin Clini plans to handle upward of 50 patients daily and wi furnish consultation services of as many physician as are required to diagnose each patient's malady Laboratory and x-ray services are included in th registration fee.

This is the first diagnostic pay clinic in Phila delphia and is comparable in some ways to th Lahey Clinic, the Mayo Clinic and the Crile Clinic

olunteer Naval Reserve Medical Divisions

In conformance with directives from the Bureau Naval Personnel forty-two (42) Volunteer Medi- l Reserve Divisions were activated January 15, 46. Four (4) more Divisions are in process of ganization. Each Division will have the following rsonnel: 75 Medical Corps; 15 Medical Service rps; 50 Nurse Corps Officers; and 250 Hospital rpsmen.

At present they are set up for training purposes it in time of national emergency personnel may be dered to duty individually or as units.

The Volunteer Medical Reserve Divisions in nnecticut are as follows:

IVISION NO.	MEDICAL OFFICER IN COMMAND
3-13 artford, Conn.	Capt. Edward H. Crosby, MCR, USNR 50 Farmington Ave., Hartford
3-15 ew Haven, Conn.	Capt. Hermann B. Arnold, MCR, USNR Beecher Road, Woodbridge
3-16 ew Haven, Conn.	Capt. Denis S. O'Connor, MCS, USNR 158 Whitney Ave., New Haven
3-17 ridgeport, Conn.	Capt. Alfred Kornblut, MCR, USNR 1539 Fairfield Ave., Bridgeport

Now is the time to make your Hotel Reservation for the 97th Annual Session of the American Medical Association at Chicago, June 21-25, 1948.

ollege of Medical Evangelists Publishes a Journal

Medical Arts and Sciences is the title of the scientific journal published by the College of Medical vangelists which made its first appearance in April 947. In the single editorial appearing in the first ssue we find this sentence: "Scientific medicine empered with humanity is the best instrument for he relief of sickness."

This publication intends to "cover the practical, ultural, and philosophical as well as the experimental, investigative, and critical sides of medicine." A large order! We shall watch with interest.

Dr. Fishbein Receives Presidential Citation For War Work

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, has been awarded a Certificate of Merit by President Truman in recognition of his "outstanding efforts as Chairman of the Committee on Information of the National Research Council, which proved to be an invaluable contribution to the war effort of the United States."

In notifying Dr. Fishbein of the award, Commander G. E. Pierce, of the U. S. Navy, secretary of the Civilian Awards Board in Washington, said it is given to "civilians for outstanding fidelity and meritorious conduct which aided in the war effort against common enemies of the United States and its allies in World War II."

The Certificate of Merit was presented at a brief ceremony in the American Medical Association headquarters in Chicago. The presentation was made by Rear Admiral J. Cary Jones, Commandant of the Ninth Naval District, Great Lakes, Ill. In addition to Admiral Jones, the Ninth Naval District was represented by Rear Admiral F. L. Conklin, MC, District Medical Officer; Captain J. F. Hooker, Commanding Officer of the U. S. Naval Hospital at Great Lakes, and Admiral Jones' aide, Commander F. N. Phillips.

Throughout the war years, Dr. Fishbein was active in the work of the National Research Council, a cooperative organization of the scientific men of America. The council, organized in 1916, served the government in a cooperative capacity during the war as the Department of Science and Research of the Council of National Defense.

Displaced Physicians

Of the 850,000 displaced persons still in camps today 1,954 are physicians. These are Poles, Latvians, Lithuanians, Estonians, Yugoslavs, Greeks, Ukrainians, and Czechoslovaks. Brought into Germany as slave laborers and concentration camp inmates, they cannot return to their Soviet-dominated lands because of fear of political and religious persecution.

Two bills are now before Congress providing for the acceptance of a fair share of these displaced persons for resettlement. Because in our immigration quotas this is an emergency situation and requires emergency measures.

STATE DEPARTMENT OF HEALTH

Stanley H. Osborn, m.d., Commissioner

Illegitimate Children

Until recently illegitimate children have had to struggle against the stigma which society attached to their status. They had to face down the ill-considered whispers, the legal discriminations, and the birth records that branded them. Social conscience finally has done something to alleviate these conditions in day-to-day relationships. The Connecticut General Assembly has taken cognizance of the situation by providing a means for their protection against unnecesary embarrassment and prying.

CONNECTICUT SAFEGUARDS PRIVACY OF BIRTH RECORDS

Connecticut statutes prohibit any reference to illegitimacy on the birth record of a child or to whether a birth occurred in or out of wedlock. Mention of the marital status of the mother is also prohibited. Also, the name of the putative father of an illegitimate child cannot be used on the birth certificate without his consent. If the father's written consent is given, the birth record of the child may be no different from that of any other. Despite these statutory protections, however, a birth record on which the child bears the mother's maiden surname, or from which the father's name is omitted, implies that the child is illegitimate.

Two measures guard against unnecessary revelation of this information: restrictions against examination of the records or the issuance of copies, and the design of an abstract form of certified copy. Only the individuals named in the record may examine a birth record: that is, the child, his father and mother; or specified officers of the state, to whom the information contained in the records will be necessary in carrying out their duties. It is expected that such officials, recognizing the intent of the law, will in their turn be discriminating in their use of the data to which they have access. This statute protects not only the illegitimate child but all Connecticut citizens from unwarranted invasion of their private concerns.

The abstract form of certified copy is termed in the law a "certification of birth registration," or "certification of birth." Such a certification contains only the name of the child, the sex, date of birth place of birth and the date the record was filed for the child. The names of the parents are omitted therefore no conclusions about legitimacy can be drawn. Since in most instances it is only the date and place of birth of the individual that need be shown and not his ancestry, the certification of birth is sufficient for most purposes. The law provides that it shall be prima facie evidence of the facts it states and shall be accepted with the same effect in regard to those facts as the original record of birth itself.

LEGITIMATION

Often the mother of an illegitimate child marries after the birth of the child. If she marries the father of the child and the birth record does not already show the facts, a new record can be prepared upon the application of the parents and the submission of appropriate proof of their marriage. There must also be, of course, no presumption that the child was a legitimate child of a previous marriage. When a new certificate has been prepared under these circumstances, the new record is placed on file instead of the original, illegitimate record and all copies thereafter issued, are of the new certificate. The original record is placed in a confidential file and is available only upon court order. When the mother of an illegitimate child marries someone other than the father of her child, the best and only procedure to make her child legitimate is to have the husband adopt the child.

BIRTH RECORDS CONFIDENTIAL IN OTHER STATES

Most states now have laws similar to those of Connecticut relating to the confidential nature of birth records for the protection of their natives. Questions relating to legitimation should be taken up with the State Registrar in the state where the child was born. Such matters should not be neglected until the child needs a copy of his birth record for the delay which is necessary to arrange for filing a new record often leads to discovery of the facts and consequent disillusionment.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Robert J. Cook, New Haven
President-elect, Mrs. Charles W. Goff, *West Hartford*
Vice-President, Mrs. James Douglas Gold, Bridgeport
Recording Secretary, Mrs. F. Erwin Tracy, Middletown
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

Congratulations and best wishes for her success re being extended to Mrs. Charles W. Goff, West Hartford, who was elected to the office of president-lect of the Woman's Auxiliary to the Connecticut tate Medical Society, at a special meeting held on anuary 28 in Hartford. The meeting was conducted y Mrs. James Douglas Gold in the absence of our resident, Mrs. Robert J. Cook.

Preceding the special meeting, a board meeting vas called to order by Mrs. Goff, then first vice-resident, and plans for the fourth annual meeting f the Woman's Auxiliary to the Connecticut State Medical Society were discussed at great length. Mrs. ames Douglas Gold, program chairman, suggested luncheon with business meeting following on April 8 at the Brooklawn Country Club, Bridgeport. This vas approved by the Board. Further details as to he program will be announced at a later date.

Mrs. G. Gardiner Russell, State legislation chair-nan, met with the members of her committee to liscuss the organizing of study groups or meeting n the counties to broaden the knowledge of the nembership on health legislative bills. You will hear nore pertaining to this matter from your county chairman.

March 3, Dr. Joseph H. Howard will speak to the Board and members interested in the speakers bureau on the Wagner and Taft bills. This is the irst in a series of talks to be given on bills pertaining o health by persons well qualified to enlighten us. These meetings are being arranged by Mrs. William Mac Shepard, public relations chairman.

A report on the feasibility of a separate news bulletin for the Woman's Auxiliary has been pre-sented to the Board. Recommendations were made by the chairman of the special committee to be dis-cussed and the decisoin of the President and the Board to be decided at a future meeting.

We may have a Historian next year. Hurrah!

Mrs. Paul S. Phelps, chairman of publicity, would be more than grateful if the counties would forward their plans for their annual meetings to her at the earliest possible moment.

Please mark your calendar.

Date: April 28, 1948—Annual Meeting.

Place: Brooklawn Country Club, Bridgeport.

FAIRFIELD COUNTY

Plans for the annual meeting to be held at Chimney Corners, Stamford, on Tuesday, April 6 are being completed by the Woman's Auxiliary to the Fairfield County Medical Association.

Luncheon and bridge parties are being given in different sections of the county to interest new members in the organization and to raise money for the rehabilitation fund of Laurel Heights Sanitorium. Mrs. Joseph H. Howard is chairman of this worthy project and is opening her home for a series of fund raising events.

HARTFORD COUNTY

Plans are under discussion for the coming annual meeting to be held on April 6. The program committee is now selecting a guest speaker and the hospitality committee making final arrangements.

We are happy to announce that Dr. Maurice T. Root has been appointed advisor to our county organization and we hope that Dr. Root will enjoy his association with us.

The final report was made by the concert committee. We realized almost $150 at our November concert and this will greatly aid our welfare fund. The welfare chairman, Mrs. Alfred Sundquist, Manchester, is now busy conducting a survey of the county for homebound children. We are trying to help with their care and entertainment in whatever way that we can.

The *Hygeia* Committee was pleased to add forty-two new subscriptions to their list.

We are lookng forward to the rummage sale, which is the first money-raising project for our newly adopted Memorial Medical Scholarship Fund.

The executive committee in charge of the rummage sale are: Mrs. Ralph T. Ogden, chairman; Mrs. Paul S. Phelps, co-chairman; Mrs. Norman Barker, Mrs. Burdette Buck, Mrs. James R. Cullen, Mrs. Harvey B. Goddard, Mrs. Joseph F. Jenovese, Mrs. J. Whitfield Larrabee, Mrs. John D. O'Connell, Mrs. Paul W. Tisher, and Mrs. Ralph M. Tovell.

MEMORIAL MEDICAL SCHOLARSHIP FUND—HARTFORD COUNTY

At the fall meeting of the Woman's Auxiliary to the Hartford County Medical Association, the membership voted to establish a memorial fund.

The purpose of the Fund will be to assist deserving young men and women to obtain or complete a medical or nursing education.

The necessary funds will be raised through an assessment of $1 per member at an appropriate time, following the death of a member of the Hartford County Medical Association.

The response to these requests will be on a purely voluntary basis. This method of raising funds will be supplemneted by rummage sales, musicales and benefits. We also hope to receive gifts and bequests.

Stoughton Drug Co. Signs Yankee's "Doctor's Orders" On WONS

The Stoughton Drug Company has signed with WONS, Yankee Network outlet in Hartford, Connecticut, to sponsor "Doctor's Orders," a Yankee Network Co-op program, for a period of 52 weeks.

"Doctor's Orders" is an interesting and informative series of programs presenting a dramatic study of a health topic each Sunday afternoon from 1:15-1:30 P. M. Following the dramatic portion of the program a doctor is invited to make an authentic statement, in simple language, of medical facts pertaining to the topic dramatized. In presenting this interview each participating Yankee Network station leaves the network and presents a "hometown" doctor who discusses, with his neighbors, his views on the topic of the dramatization. All programs in this series are aired in cooperation with the Medical Societies of the six New England States, and are written and produced by Radio Productions, Inc., of Providence.

The First Woman President

The New England Journal of Medicine right attributes to Boston the distinction of being th birthplace and family home of the first woma president of the American Public Health Associ tion, Martha May Eliot, M.D. It overlooked the fac however, that Dr. Eliot is a member of the Ne Haven County Medical Association and of th Connecticut State Medical Society.

Dr. Eliot's association with Connecticut medici began in 1921 when she became the first woma resident physician at the New Haven Hospital, wit a teaching position at Yale University School o Medicine. It was during these early days while New Haven that she made a noteworthy study o rickets for the United States Children's Bureau, a accomplishment which later carried her to Wash ington as a member of the staff of that bureau.

During all these years culminating in her fame author of the Emergency Maternal and Infant Ca program Dr. Eliot has maintained her membershi in New Haven and Connecticut societies. Sh assumed her new office on October 9, 1947.

From Jackson County, Kansas, comes this bit o logic:

About Nurses Being Overworked and Underpaid

The well trained nurse rises when a physicia enters her presence—Why? Is it because she has bee reduced to such a state of servility that she must pa homage to her "lord and master," the doctor? Nor sense! She rises in deference to a *representative o the profession* of which she is a part. Quite inc dentally, a gentleman, be he layman or physicia stands in a woman's presence when practicable t do so.

Ten dollars a day for an eight hour shift isn exactly peanuts, particularly if you are the pair wracked fellow in the nine dollar a day room, or th sad faced relative who is footing the bill. Of cours it isn't "big" money either in this day of spiralin living costs, but for the little Kansas girl who use to chase rabbits on her father's farm and help wit putting up the alfalfa we still would call it a fai amount of "hay"!

CORRESPONDENCE

Doctors and the Sales Tax

o the Editor:

The Connecticut Sales Tax Law is a big headache a lot of people.

It is especially hard on Connecticut business uses, including the surgical dealers, because of e very considerable demand of time and money imposes on businesses for administration, collec-n, policing, and reports.

In our opinion, it is also especially hard on and fair to Connecticut doctors, exempting, as it does, ctors' supplies and equipment to hospitals but t to doctors, and exempting, as it did until last nth, drugs only to the patient on prescription, t not to the doctor himself.

In our interest and yours we've been stirring up much attention as our own efforts will to the ortcomings of the Connecticut Law as affecting e medical profession and medical business. In ticipation of some modification at the coming ecial session of the Connecticut State Legislature lled to review the Sales Tax Law, we've either ritten to or talked with ten or twelve of our rious State legislators, the Chamber of Commerce, e Tax Payers Research Council, Yale Professors irchild and Saxon whom the Governor asked to vestigate, Tax Commissioner Walsh, the Con-ecticut Public Expenditure Council, Governor IcConaughy himself, and four other Connecticut rgical dealers. We've also written to twenty-ven other surgical dealers in other states where ey also have a Sales Tax to learn if their law oper-es as unfairly.

There is some talk of reducing the tax from 3 per ent to 2 per cent at the coming session in Hartford. 's OK with us to reduce the tax rate, but in itself at's no help. Can anything be done, like author-ing a seller's hold-back of say 20 per cent of their x receipts, to compensate Connecticut business for e very considerable work they are doing (in our ase providing an extra bookkeeper) to collect and eport the tax?

Tax Commissioner Walsh's new regulation No. o, now giving to doctors the same tax exempt advantage that their prescription patients have always had on drugs, also is OK with us. Why doesn't the law also exempt orthopedic appliances on prescription same as drugs? Are crutches less important than aspirin? Regulation No. 20 is a step in the right direction, but it doesn't go far enough.

Two or three men with whom we have corresponded who hold influential positions have said that it occurs to them that some further study might be given to the possibility of exempting at least the major items of equipment used by doctors. Well, why not! And why not all the equipment and supplies doctors use? The law already exempts hospitals from a tax on exactly the same articles taxed to doctors; yet doctors do exactly the same work as hospitals, including $3,000 of charity work each annually on the average, according to a recent national survey. So what's the difference?

Other exemptions are made by the law, based on the nature of the item, without this discrimination between classes of purchasers. The law doesn't exempt food to firemen, but tax food to policemen. The law doesn't exempt containers, milk containers for instance, to private school children, but tax containers to public school children. But the law ironically does exempt medical necessities to hospitals, while taxing medical necessities to doctors.

I understand there is considerable likelihood under the proposed revision of the Tax Law that "tools of production" will be tax exempt to Connecticut factories. Doctors' "tools of production," whether a roll of adhesive, 10 cc. of vaccine, or an x-ray, should similarly be tax exempt to Connecticut doctors!

Doctors who come in our store and on whom our ten salesmen call throughout Connecticut have repeatedly expressed their personal and individual tax gripes to us. Are Connecticut doctors collectively, as are so many other groups, pressing for revisions to lessen the impact of this law on their own profession? It seems to us that joining with the active manufacturers' group might be more successful than a separate approach to the matter, by getting "doctors' supplies and equipment" to be included under "definitions" in the amendment they propose to exempt "tools of production."

Very truly yours,
The Professional Equipment Co.
Darton E. Greist

Smoke From the Past

To the Editor:

The mention of the name of Dr. Vine Utley in the JOURNAL* rang a bell in my memory and obeying the bell signal I opened the old records of the New London County Association.

Under the date of the fourth Tuesday of September 1807 I find, "Doct'r Vine Utley producing a certificate of his regular standing as a practitioner of Physic and Surgery in the State of New York, and wishing to become a member of this Society, a vote was taken and he was regularly admitted."

He attended meetings regularly and paid his dues on time and even got to deliver a dissertation in September 1817. And then, something happened, for, on the fourth Tuesday of September 1819 at the meeting in the house of Capt. Thos. Allen in New London it was resolved: "That Doct'r Vine Utley be expelled from this society for indecorous, insulting and abusive language held in open meeting, toward this society. This vote was passed with but one dissenting vote."

Brother, that must have been a hot meeting. I can find no other record of expulsion of a member.

Alfred Labensky

*See JOURNAL, page 53, January 1948

To Rebuild Jackson Memorial Laboratory at Bar Harbor

Records and equipment, used in twenty-five years of cancer research at the Jackson Memorial Laboratory, were lost when forest fires engulfed Bar Harbor, Maine, and destroyed the laboratory. Building cost of the site was $150,000. A week following the catastrophe trustees of the institution announced that immediate plans were underway to restore the laboratory and that architects had been appointed to draw plans for reconstruction. It will be erected on the same site. In the meantime, research workers are continuing their cancer studies at similar institutions in the East.

Dr. C. C. Little, director of the Laboratory, has announced the loss of almost 90,000 mice representing 30 strains and irreplaceable records tracing experimental work through 200 mice generations. He said he is seeking to recover mice strains from laboratories which he formerly supplied. He asked all scientific sources to send him reprints of technic papers on genetics, experimental embryology, ca cer research and experimental medicine.

The Maine Cancer Society immediately gave D Little a check for $10,000 to be used as he saw fi Douglass Poteat, A.C.S. executive vice-presiden said he would transmit to Dr. Little another chec for $50,000—the grant of the Damon Runyon Ca cer Fund.

Dr. Little estimated rebuilding costs at $500,00 but he said the loss of scientific material and da was beyond evaluation.

New Diabetes Magazine

In January 1948 the American Diabetes Associa tion began publication of its new magazine entitle *ADA Forecast*. The purpose of *ADA Forecast* is t give the physician an additional aid in the treatmer of his diabetic patient. It will serve as a monthl messenger—the doctor's messenger—delivering t the diabetic patient helpful articles by authoritic in the field; basic facts on diet; and inspiration articles which will keep up the patient's courage i the rigorous routine of his disease. It is hoped tha the reader of *ADA Forecast* will have a bette understanding of the need for close cooperatio with his physician.

The first issue of *ADA Forecast* contains an articl on "Healthy Though Diabetic" by Elliott P. Josli of Boston.

Medical School Dean Goes to Parke-Davi

Parke-Davis Company has appointed Dr. P. J Gray as medical consultant. Dr. Gray comes t Parke-Davis with an exceptional medical back ground. A graduate of Johns Hopkins Universit with an M.D. degree, and of the Harvard Schoo of Public Health with an M.P.H., he served in publi health work for many years, including posts wit the United States Marine Hospital in New Orleans the state of California and the city of San Francisco and the Michigan Community Health Project of th W. K. Kellogg Foundation. He also is an educator having lectured in public health at the University o California, served as dean of the School of Medicin of the Medical College of Virginia in Richmond and also as dean of the School of Medicine, Univer sity of Oklahoma, and superintendent of the Univer sity hospitals.

OBITUARY

Donald Robert MacLean, M.D.
1874 - 1946

Donald Robert MacLean was born in Middletown, New York, on July 23, 1874, and died at Stamford, Connecticut, on November 4, 1946. His preliminary education was received in the schools of Mount Vernon, New York, and he was graduated from the Baltimore Medical College in Baltimore, Maryland, in 1901. He served internship appointment at Maryland General Hospital, Baltimore, Maryland, and at Mount Vernon, New York, Hospital. In 1902 he began the practice of medicine in Stamford, Connecticut.

Early in his career, he was attracted to the field of anesthesia, and gradually devoted more and more of his time to this specialty. In 1920 he gave up his general practice to become one of the few full time anesthesiologists in this country. For many years his was a familiar figure at the national conventions of the pioneers in his specialty. He was one of the early members of the International Anesthesia Research Society and of the American Society of Anesthesiologists; he was awarded fellowships in both organizations.

He served on the staff of the Stamford Hospital as attending anesthetist throughout his entire career. He was also a member of the Stamford Medical Society, Connecticut State Medical Society and of the American Medical Association. He was a member of the Stamford Baptist Church.

Dr. MacLean retired from active practice because of ill health in 1936, and he failed gradually until his death in 1946. During his last years he was consultant anesthesiologist at both Stamford Hospital and St. Joseph's Hospital, Stamford.

Dr. MacLean is remembered by his fellow practitioners as the possessor of a lovable character, a ready humor, and an unusually keen memory for the names of all individuals he met. He will especially be remembered, however, as the man who put the practice of anesthesiology in his community on a very high plane.

Frank D'Andrea, M.D.

E. Everett Rowell, M.D.
1878 - 1947

Dr. E. Everett Rowell, x-ray specialist and retired city official, died July 13 at his home, 104 South Street, Stamford, after a long illness.

Born in Lancaster, N. H., September 13, 1878, the son of Dr. Charles E. and Arletta Bolles Rowell, he had been a practicing physician in Stamford since 1900. He came to that city with his parents in 1880.

Dr. Rowell was a graduate of King's School and of Hahnemann Medical College. He entered general practice in Stamford and became city Health Officer in 1913. He served in this position until 1917 when he resigned to enter the Army in the first World War. He acted as the x-ray specialist in this country and overseas for the Boston University unit. Dr. Rowell continued in this specialty following the war, and was the radiologist for St. Joseph's Hospital of Stamford, the Greenwich and Norwalk General Hospitals.

His medical affiliations included the American Roentgen Ray Society; Fellow of the American College of Radiology; American Radium Society of North America; American Medical Association, the State, County and the Stamford Medical Society.

Prominent in Republican party circles, Dr. Rowell served in various city positions. He was elected to the Common Council in 1934 and remained a member until his resignation early this year because of ill health. His unselfish public service to Stamford will be long remembered.

Besides his wife, Mrs. Madeline Geronimo Rowell, he is survived by a brother, Dr. James Frederics Rowell of Lawton, Okla.

Joseph P. Connolly, M.D.

SPECIAL NOTICES

CONNECTICUT VA MEDICAL SOCIETY

March 4
Management of Pancreatic Diseases
By Dr. Jack Gurwitz, Asst. Chief Surgeon, Newington

March 11
Recent Advances in the Treatment of Carcinoma of the Thyroid Gland
By Dr. Joseph Heyman, Attending Surgeon Cook Memorial and Mt. Sinai Hospitals; Consulting Surgeon at the Institute of Living.

March 18
"Discharge Neurosis" of the Veteran
By Dr. Isadore Schnap, Chief Mental Hygiene Clinic, VA Hartford Regional Office and Dr. Simon Goldfarb, Asst. Chief

March 25
Motion Picture "Penicillin in Medicine and Surgery"

Meetings held at 8:30 A. M. at 95 Pearl Street, Hartford.

NEW HAVEN MEDICAL SOCIETY

Wednesday, March 3
Dr. Ephraim Shorr, Cornell University
"Medical Shock, Illustrated with a Moving Picture"

Wednesday, March 17
Dr. Richard Cattell, Lahey Clinic
"Treatment of Thyrotoxicosis"

Wednesday, April 7
Dr. I. C. Rubin, Columbia University
Subject to be announced

Wednesday, April 21
Dr. Paul Magnuson, Assistant Chief of U. S. Veterans Administration
"Arthritis"

COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

Preliminary Program:

Conference of State and County Medical Society Officers at the Copley Plaza Hotel (Boston) on the afternoon of Sunday, March 7, 1948, 1:30-5:00 P. M.

Theme: The New England Doctor and His Public

"Listening to the Doctor"

Speaker:
James S. Powers, Director, Yankee Network Institute

Discussant:
John F. Conlin, M.D., Director of Medical Information and Education, Massachusetts Medical Society

"The Doctor and His Medical Society as Sources of New

Speakers:
From the Viewpoint of a Large City Newspaper
Maurice Cronan, City Editor, Hartford (Conn.) Coura
From the Viewpoint of a Smaller City Newspaper
Gearld E. McLaughlin, Managing Editor, Rutland (Vt Herald

Discussant:
James Burch, Director of Public Relations, Connectic Medical Society

"The Doctor's Role in Community Programs"

Speaker
Hugh R. Leavell, M.D., DR.P.H., Professor of Public Heal Practice, Harvard University

Discussant
Robert O. Blood, M.D., Former Governor of the State New Hampshire

Roundup of the New England States. Discussion from th floor by State and County Society Officers and Commi teemen.

CHANGE DATE OF INDUSTRIAL CONFERENC ON ALCOHOLISM

The first Industrial Conference on Alcoholism, origi ally scheduled to be held on March 15, will now be hel on Tuesday, March 23.

Sponsored by the Chicago Committee on Alcoholism, th one-day conference will be held in the Terrace Casino the Morrison Hotel, Chicago.

Dr. John I. Norris of the Eastman Kodak company Rochester, N. Y., will be the keynote speaker at th conference's luncheon to be held in the Mural room of th Morrison. Norris, a Fellow of the American Associatio of Industrial Physicians and Surgeons and of the Amer ican Medical Association, has been doing considerable wor on the subject of alcoholism through the Rochester Com mittee for Education on Alcoholism. His talk will be high lighted with the latest information available to industry.

The conference has been designed to bring to the atten tion of industry leaders throughout the country facts per taining to the problem of alcoholic employees and to discus ways and means of overcoming the problem.

EXTENSION COURSE IN HARTFORD OF NEW YORK PSYCHOANALYTIC INSTITUTE

The School of Applied Psychoanalysis, which is a depart ment of the New York Psychoanalytic Institute, plans seminar for physicians to familiarize them with psycho analytic concepts. The lecturer will be Dr. Samuel Atkins a member of the teaching staff of the New York Psycho

alytic Institute. There will be eight weekly sessions from 8:30-10:30 P. M. The topic will be "Problems encountered in general practice and in specialized practice: Neuroses, early and advanced manifestations of phychoses, behaviour problems in children and adults, marital problems, characterdeviation, alcoholism and other addictions, psychosomatic problems, psychological determinants in organic illness, problems in involutional period, etc.; indications and contra-indications for psychoanalytically oriented psychotherapy." The course will begin during the second week in March. Registration fee $20. Physicians interested in this course may contact Dr. Richard Karpe, 801 Farmington Avenue, West Hartford.

FIFTH POSTGRADUATE COURSE IN INDUSTRIAL MEDICINE

The Long Island College of Medicine announces the forthcoming presentation of its Fifth Postgraduate Course in Industrial Medicine. This course will be given during the two week period April 5 to April 16, 1948, and will be conducted under the auspices of the Department of Preventive Medicine and Community Health by a distinguished group of more than sixty leaders in industrial medicine, authorities in allied fields and members of the faculty.

This presentation continues the series of orientation courses in industrial medicine begun by the College in the fall of 1942, which has gained national and international prominence in promoting the health of gainfully employed workers and their families. It will also be the initial undertaking of the new Institute for Occupational Health of the Long Island College of Medicine, a unit of the College recently established to devote particular attention to the problems of health in relation to occupation.

The main objective of the course is to provide physicians engaged in full time or part time industrial practice, as well as those who wish to enter this field, an opportunity to become acquainted with the most recent developments in the rapidly expanding specialty of industrial medicine. Although arranged primarily for graduate physicians, the course will be of special interest and value to industrial nurses, hygienists and engineers, personnel workers, representatives of management and labor, as well as to other professional and business groups concerned with the health of employed persons.

Tuition for the entire course will be $75. Inquiries should be addressed to Dr. Thomas D. Dublin, Department of Preventive Medicine and Community Health, 248 Baltic Street, Brooklyn 2, New York.

PHILADELPHIA COUNTY ANNUAL POSTGRADUATE INSTITUTE

The Twelfth Annual Postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, April 20-23, 1948. Due to the success of last year's program it is again planned to present the material in the form of a series of symposia on subjects of practical interest to the general practitioner and specialist.

Among the topics to be covered are Problems in Obstetrics and Gynecology. Newer Drugs and Procedures, Surgery of the Ambulatory Patient, Fractures, the Painful Breast, Neuropsychiatric Disorders, Problems of the Aged, the Acute Abdomen, Gastrointestinal Disorders, and Otolaryngological Problems.

In addition to the regular morning and afternoon programs there will also be two evening sessions at the Society Building on the subjects of Cancer and Pediatrics.

The usual large number of technical exhibits will be important features of the sessions. Registration fee for the entire meeting is $5. A copy of the preliminary program and any further information may be secured by writing to Gilson Colby Engel, M.D., Director, 301 South 21st Street, Philadelphia 3, Pa.

AMERICAN ACADEMY OF PEDIATRICS

The Areal Meeting of the American Academy of Pediatrics will be held at the Hotel Statler, Buffalo, New York, April 29 to May 2, 1948.

Members of State Medical Societies are welcome to attend. The registration fee will be $5 for such non-members. This is in addition to the regular $5 registration fee for members making a total of $10 for non-members of the Academy. This registration fee includes a ticket to the banquet.

Registration may be made ahead of time by writing to Dr. C. G. Grulee, Sec.-Treas., American Academy of Pediatrics, 636 Church Street, Evanston, Illinois, enclosing a check for $10 or registration may be at the time of the meeting.

CLINICAL RESEARCH MEETING AT THE NEW YORK ACADEMY OF MEDICINE

The New York Academy of Medicine will hold a meeting Thursday evening, April 29, 1948 at which investigators of New York City and vicinity may present results of original research in Clinical Medicine.

This meeting is being arranged by the Committee on Medical Education of the Academy with the following stipulations:

(1) Presentations will be confined to original research work in Clinical Medicine (including medicine, surgery, pathology, obstetrics and all other clinical branches), or be applicable to Clinical Medicine.

(2) Preference will be given to papers which have not been presented before a national or local society (other than intramural).

(3) In submitting application, investigators are requested to state whether this work has been published or has been submitted for publication; also, in cases where investigator is working under the head of department of a hospital or research institute, approval of the head of department must accompany the application.

Presentations will be strictly limited to 12 minutes. A brief period of free discussion will follow each presentation. The publication of presentations is not a necessary condition but the Academy plans to publish in the June Bulletin, ab-

stracts of presentation if the author so desires. In order to expedite publication of abstracts, the Committee requests that the abstract submitted by the investigator be carefully prepared in the form in which publication is desired with the understanding that publication of the abstract in the Bulletin shall not preclude publication by the author in any other journal.

The Committee extends an ivitation to all research workers of Greater New York City and of neighboring cities within a radius of one hundred miles to submit *an abstract in triplicate*, not to exceed 500 words in length, of proposed presentation to the Secretary of the Committee on Medical Education of the Academy *not later than March 8, 1948*. A formal invitation to participate in this program will then be extended by the Committee to the authors of papers selected for presentation.

SECOND ANNUAL AMPUTEE INSTITUTE

Hasbrouck Heights Hospital, Hasbrouck Heights, N. J. April 1, 8, 15, 22, 29, 1948

The Second Annual Amputee Institute will be held each Thursday in April at the Hasbrouck Heights Hospital, Hasbrouck Heights, N. J., for the purpose of:

1. Correlating the efforts of the general surgeon, the orthopedic surgeon, the limb manufacturer, and associated interests;

2. Promoting for civilian amputees the same care and help in adjusting to changed physical condition as the Army and Navy provided for members of the armed forces who lost limbs during World War II.

Sponsors will be the American Medical Association's Council on Industrial Health, the Hasbrouck Heights Hospital Association, the National Council on Rehabilitation, the New Jersey State Elks Crippled Children's Committee, Orthopedic Appliance and Limb Manufacturers Association, the New Jersey Rehabilitation Commission, the New Jersey Crippled Children's Commission, and the Federal Security Agency's Office of Vocational Rehabilitation.

The Amputee Institute again will be under the personal direction of Dr. Henry H. Kessler, chairman of the Rehabilitation Committee of the AMA's Council on Industrial Health and consultant to the Office of Vocational Rehabilitation on orthopedics and prosthesis. The seminars will stress:

1. Psychological preparation of the patient.

2. The surgical care of the patient.

3. The orthopedic after-care of the stump.

4. The selection, manufacture and fitting of the proper type of prothesis.

5. Training of the amputee to use his limb.

In connection with this Institute an intensive course in amputation, selection of prosthesis, etc., will be given for physicians and associated workers on these days from 9:00 A. M. to 12 NOON, 2:00 P. M. to 5:00 P. M.

The program is as follows:

April 1
National Program for Amputees
General Principles of Amputee Rehabilitation

April 8
Surgery of Amputations
After-care of Stump

April 15
The Selection, Manufacture and Fitting of the proper ty of prosthesis, including fabrication

April 22
Below and above knee amputation
Below and above elbow amputation
Bilaterals

April 29
Disarticulation of hip; hind quarter amputations
Training of Amputee; walking; balance; posture; etc.

Registration fee—$10.

Please notify Registrar, Hasbrouck Heights Hospital, you plan to attend.

AMERICAN BOARD OF OPHTHALMOLOGY

Practical Examinations—1948:
Baltimore, May 20-25
Chicago, October 6-9

Written Qualifying Tests will be held annually, probab in January of each year. Applicants for the January 19 Written Qualifying Test must be filed with the Secreta before July 1, 1948.

A supplement of diplomates from January 1947—Janua 1948 will be sent gratis to all purchasers of the Boar Directory. This supplement is arranged alphabetically ar geographically. No biographical material is included.

Diplomates are urged to keep the Board office informe of all changes of address, so that the files can be ke up-to-date.

Officers for 1948: Drs. Goar, Chairman; Dunnington, Vie Chairman; Beach, Secretary-Treasurer; Dunphy, Assista Secretary.

Executive office: Cape Cottage, Maine.

DR. FISHBEIN TO GIVE COURSE IN MEDICA WRITING

Dr. Morris Fishbein, editor of the *J.A.M.A.*, will give a instructional course in medical writing at the next annu meeting of the Mississippi Valley Medical Editors' Assoei tion, to be held at Springfield, Ill., September 29 during th annual meeting (September 29, 30, October 1) of the Mi sissippi Valley Medical Society in that city. No registratio fee will be charged to members of the Association.

The Medical Editors' Association is contemplating change in both its constitution and name as it is felt that the nam "Editors" is entirely too restrictive, and the name Medic "Writers" or "Authors" Association would be more appro priate. While every medical editor is a medical writer, ever medical writer is not a medical editor. Since the prineip purpose of the Association is to improve medical writing hundreds of physicians should be interested in the organi zation, as most progressive physicians write articles and ar interested in any effort to improve medical literature.

All interested in knowing more about this non-profi

ganization, or attending the meeting next September, ould communicate with the Secretary, Dr. Harold Swanrg, 209-224 W.C.U. Bldg., Quincy, Illinois.

PUBLIC HEALTH FELLOWSHIPS

Fellowships leading to a Master's Degree in Public Health the field of Health Education are again being offered to y qualified United States citizen between the ages of 22 d 40, according to a statement released by the United ates Public Health Service, Federal Security Agency. nds are available through a grant from the National Foundtion for Infantile Paralysis.

Candidates must hold a Bachelor's degree from a recogzed college or university at the time the application is ed, and must be able to meet the entrance requirements the accredited school of public health of their choice. oof of acceptance at such a school must be furnished fore applications are submitted to the Fellowship Awards mmittee for consideration. In addition to the Bachelor's gree, courses in the biological sciences, sociology and edution are required. Training in public speaking, journalism, ychology and work in public health or a related field is nsidered desirable.

The fellowship consists of 8 or 9 months' academic work, hich begins with the fall term in 1948, and three months supervised field experience in community health educan activities in a local health department. The academic ining includes courses in public health administration, idemiology, public health and school education, problems health education, community organization, information chniques, and others.

Veterans are encouraged to apply, and will be paid the fference between their subsistence allowance under the I Bill of Rights and the monthly stipend of $100 for ngle veterans or $150 for married veterans. Employees of ate or local health departments are not eligible, since ederal grants-in-aid are provided through the States for ch training.

Information and application blanks may be obtained by riting the National Foundation for Infantile Paraylsis, 120 oadway, New York 5, New York.

THE SCHERING AWARD FOR 1948 ANNOUNCED

The interesting and vitally important subject of "The ole of Hormones in the Maintenance of Pregnancy" is e basis for The Schering Award for 1948. For the three st manuscripts submitted by undergraduate students of merican and Canadian medical schools on such a desigted phase of endocrinology, The Schering Award annuly offers cash prizes of $500, $300 and $200. Through his forts in preparing a manuscript for the competition, the edical student acquires useful information in various imortant fields of endocrinology. Consequently, The Scherg Award receives high praise each year from deans of edical schools, their faculties and the student participants. he Schering Award is sponsored by the Schering Corporaon of Bloomfield, New Jersey.

OPPORTUNITIES IN OVERSEAS HOSPITALS

1. The U. S. Army Medical Department announces the availability of opportunities for advanced training and experience in the various special fields of medicine and surgery in overseas Army hospitals. These hospitals are registered with the American Medical Association, and this training may be acceptable by the specialty board as part of the period usually required to be spent in limited practice and experience prior to admission for examination. Interested members of the medical profession who have completed the formal training requirements for certification in one of the special fields are eligible to apply for these positions. On January 1, 1948 the following opportunities were available and will be kept open until filled:

SPECIALTY	NO. OF OPENINGS
Eye, Ear, Nose & Throat	7
Obstetrics & Gynecology	14
Anesthesia	7
Ophthalmology	3
Otorhinolaryngology	3
Neurosurgery	1
Orthopedic Surgery	5
Thoracic Surgery	1
Plastic Surgery	1
Radiology	11
Internal Medicine	24
Dermatology	3
Neuropsychiatry	15
Pediatrics	10
Cardiology	2
Pathology	1

(There are also 21 positions in general surgery and 5 positions in urology, but these boards specify "supervised practice" and it has not yet been determined whether or not the hospitals will be approved by these boards. Full approval of these specialties is being sought and inquiries are invited.)

Positions offered will be in the following hospitals:

NAME	LOCATION	BED CAPACITY
97th General Hospital	Frankfurt, Germany	1000
98th General Hospital	Munich, Germany	1000
110th Station Hospital	Vienna, Austria	150
120th Station Hospital	Beyreuth, Germany	325
124th Station Hospital	Linz, Austria	150
130th Station Hospital	Heidelberg, Germany	250
250th Station Hospital	Regensburg, Germany	150
279th Station Hospital	Berlin, Germany	350
317th Station Hospital	Wersbaden, Germany	150
319th Station Hospital	Bremerhaven, Germany	600
385th Station Hospital	Nurnberg, Germany	350
387th Station Hospital	Stuttgart, Germany	453
388th Station Hospital	Giessen, Germany	250

These locations provide excellent facilities and equipment, a wealth of clinical material and the services of visiting consultants who are outstanding specialists in the various fields of medical practice. In addition, opportunities will be afforded to observe the work of notable scientists and physicians in German and Austrian Universities.

2. The applicant may avail himself of this training for periods of one, two or three years. Those applicants who are selected and who hold reserve commissions in the Medical Corps, will usually be recalled to active duty in the highest grade attained prior to release from previous active service. Those who do not hold such reserve commissions will be tendered a reserve commission in the Medical Corps in keeping with their age, years of professional experience and prior service in any branch of the Armed Forces. Prior military service is not required. Individuals who are members of the U. S. Naval Reserve must transfer to the Army Reserve before being called to active duty. Families of married applicants will be allowed to accompany them to the place of duty. Suitable quarters are available. Families of individuals who do not declare their desire to serve for periods to exceed one year cannot be transported at Government expense.

3. Eligible physicians are invited to communicate with The Surgeon General, U. S. Army, Washington 25, D. C., for further information. Inquiries should include the following information: name, address, age, nationality, marital status, dependents with age of each, medical school and graduation date, internship and date, details of graduate training, specialty and geographic location desired, contemplated length of service, details of prior military service.

An Educational Awakening

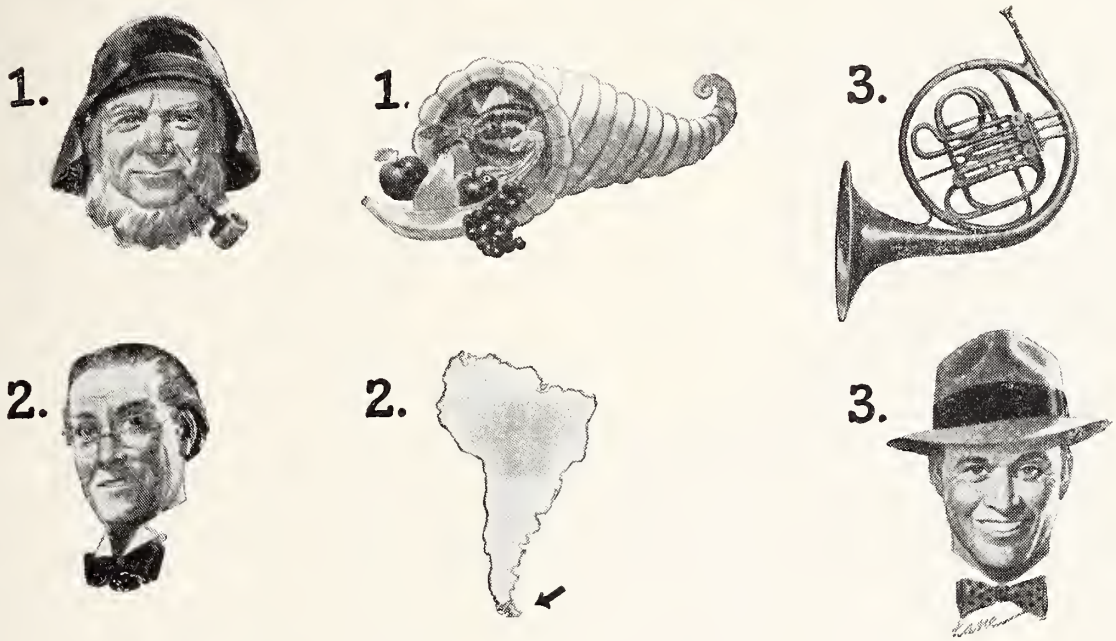
By a vote of the Faculty of Arts and Sciences, Harvard College has discontinued the B.S. degree and will after this grant the A.B. degree only. Effective for the graduating class of 1950, the new regulations for the Bachelor's degree will require that the candidate for admission to Harvard College present a satisfactory secondary-school record, including three years of Latin, two years of Greek, or three years of mathematics. Exceptions may be made for highly qualified students whose preparatory work has been completed in schools which do not provide opportunity to meet the regular requirements.

At last there is a hopeful sign that it may come to pass that students intending to embark on the study of medicine will have a good foundation on which to build with the result that there will be more good doctors rather than just more doctors. Studies made by the Association of American Medical Colleges over a long period of years have shown that more often than not students with the A.B. degree rank the highest and have the fewest failures, whereas students with the B.S. degree usually are at the bottom of the class, outranked by even the two year college students and, of course, the three year students. Furthermore, it has also been shown that students offering much credit in Latin, Greek and mathematics outrank all other students. That is especially true of the mathematicians. Their mental processes rather than their memorizing ability have been stimulated and developed. In the study of medicine, thinking is of much more importance than memorizing. All medical educators are agreed on that point. The studies mentioned above also show that it is not a question of how much time has been spent in college that determines the quality of performance in medical school as is how that time was spent; what courses of study were taken and have the student's mental processes been stimulated.

New Height-Weight Records

The Joint Committee on Health Problems in Education of the National Education Association and the A.M.A. has tentatively adopted (to be confirmed by mail vote) two suggested revisions of the height and weight charts for school children. One, submitted by Prof. Howard V. Meredith, based on data obtained at the University of Iowa experimental schools, Iowa City, will be used for research and study. The other plan, proposed by Dr. Fred V. Hein of our Bureau of Health Education, will be used for routine record keeping. The latter calls for pupil participation on reaching the age of responsibility, in weighing and measuring one another and keeping their own records. Both emphasize individual recording and avoid comparison of the individual pupil with his fellow pupils, since this group comparison has resulted in a feeling of inferiority in children not making satisfactory progress by "average" health standards. The Iowa plan classifies the child by stature zone (tall, moderately tall, average, moderately short, short, heavy, moderately heavy, average, moderately light and light). Progress in his stature zone is recorded, and any considerable deviation will indicate need for referral to a physician.

Adopted tentatively also is the Giddings report on a nutritional program for schools (Dr. Glenville Giddings, Atlanta, Ga.). This program sets up standards for teachers' use in determining the nutritional status of the school child.



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Let U. S. Savings Bonds fill up your personal Horn of Plenty . . . for the years to come!

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NEWS
from County Associations

Fairfield

Bruce S. Weaver, pathologist and bacteriologist at Stamford Hospital for 32 years, died on January 8 after a long illness. In October 1945 Dr. Weaver gave up his position at Stamford Hospital and accepted a similar one at St. Joseph's Hospital in order to limit his activities.

Ralph F. Sikes, Norwalk health officer since May 1, 1946 has resigned to accept the post of Commissioner of Health of Yonkers, N. Y. Mayor Freese in commenting on Dr. Sikes' resignation said he had performed an excellent job for the citizens of Norwalk.

At the annual meeting of the Stamford Medical Society Solomon Friedberg was elected president; Wendell J. Washburn, first vice-president; Frederick W. McFarland, second vice-president; Lindo P. DiFrancesco, treasurer; and Joseph Fine, secretary.

Edward P. Kemp, a chief surgeon at St. Vincent's Hospital, Bridgeport, was installed as president of the hospital staff at the annual dinner January 27. Dr. Kemp succeeds Arthur J. Sekerak. Leonard F. Del Vicchio is the new vice-president and John W. Buckley the secreatry.

Mary Adams, a pediatrician in Riverside, addressed the first of a series of health meetings sponsored by the Riverside Parent-Teacher Association recently on the subject of "War Babies." Dr. Adams said that the war's effect on babies was indirect in that the parents have been affected. This effect is mental rather than physical, giving the baby a feeling of insecurity. The speaker stressed the importance of actual experience in handling and caring for babies before their arrival. This affords the new mother a more relaxed attitude, she explained.

Reading of books is an excellent source of knowledge, provided they are read objectively, Dr. Adams said. She reminded mothers to bear in mind the acuteness of a baby's sense of motion, hearing and touch. One must learn sureness of touch and a quiet smooth attitude, said the speaker.

Dr. Adams discussed the subjects of feeding, crying, sleeping and training. She particularly emphasized the importance of enjoying the baby and keep ing a friendly attitude. When attempting to brea bad habits, always look for the source rather tha resorting to direct punishment, she warned parent

An open discussion followed the lecture.

Hartford

Edwin M. Griswold, town health officer, is th new medical examiner for both Glastonbury an Marlborough. He was appointed to the post b Coroner Louis W. Schaefer to succeed Dr. Lee Whittles, who has resigned after 25 years of servic

Benjamin B. Robbins of Bristol, health officer o that city for 22 years and a past president of th Hartford County Medical Association, died sud denly on the evening of January 9 while attending local high school basketball game. Flags were order ed displayed at half mast by Mayor Casey until afte the funeral services.

George W. Dunn, well known surgeon of Nev Britain, died at his home on January 31. Dr. Dun was a former chief of staff of the New Britai General Hospital, a past president of the Hartfor County Medical Association, and had practised i New Britain for 36 years.

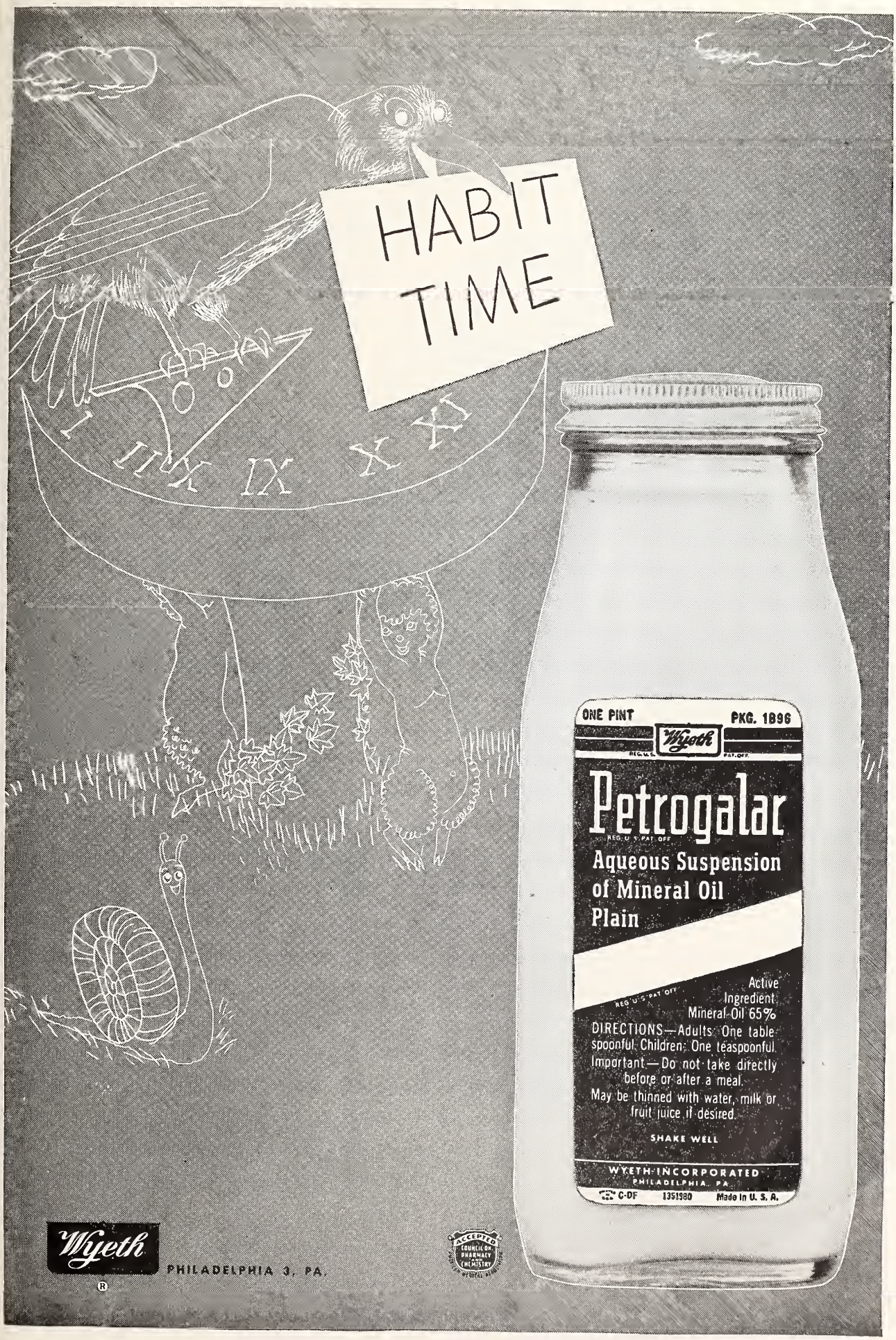
The New Britain Medical Society elected th following officers at the annual meeting on January 21: George W. McMahon, president; Raoul Benoit vice-president; Harold M. Clarke, secretary-treas urer; to the executive board the retiring president L. B. Slysz. Paul W. Tisher addressed the meetin on "Phonetic Conversions."

Martin I. Hall of Bristol has resigned as medica director for the New Departure Division of Gen eral Motors Corporation to take up private practice His office will be located at 19 High Street, Bristol

During 1947 patients admitted to the Hartfor Hospital numbered 30,119, an increase of more thar 2,000 over 1946, according to the hospital's annua report.

Of the total number of admissions, 6,465 were emergencies, representing an increase of 2,289 ove the 1946 figure, and outpatient visits numbered 11,742, as compared to the total of 10,205 for the previous year.

Medical services for the year were performed by 570 physicians, classified as follows: 133 staff physicians, 28 consultants, 408 physicians on the courtesy staff, and 73 resident doctors and interns. The num-


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ber of people of the hospital's payroll equalled about 1,100 full time employees. This included 238 graduate nurses, assisted by 215 students, as well as auxiliary workers and volunteers. The report states that the hospital furnished services for an average of 738 patients daily.

Burnhardt Zeman, one of the senior members of the staff of Mt. Sinai Hospital, Hartford, was honored recently at a testimonial dinner given by directors and staff of the hospital at the Tumble Brook Country Club. More than 75 attended. Morris Tuch who was to have been honored was unable to be present.

The two doctors were among the original medical staff that founded Mt. Sinai 25 years ago and are the first two men of that staff to reach retirement age. Both are 65 years old and will remani as consultants at the hospital.

Dewey Katz, chief of staff of Mt. Sinai, presented a testimonial scroll to Dr. Zeman at the dinner and praised his record of service to the hospital in the past 25 years.

Both doctors will participate in the laying of the cornerstone next spring of the new Mt. Sinai building on Bloomfield Avenue.

Litchfield

Russell Webber of Woodbury, allergist at Woodbury Hospital and Chase Dispensary, has been elected to the American Academy of Allergists.

Clark K. Peterson of Lakeville has been appointed chief of staff of the Sharon Hospital. A practicing local physician, he has been associated with the hospital for 37 years. In addition to his new duties Dr. Peterson is medical examiner and health officer for the Town of Salisbury. He was tendered a testimonial dinner on Saturday evening at Oakhurst, Millerton, N. Y., by the members of the staff of the hospital. About 40 were present. His appointment fills the vacancy left by the death of J. S. Chaffee of Sharon, founder of the hospital.

Middlesex

Middlesex County welcomes Dr. Clarence Harwood who has opened an office for the practice of pediatrics on College Street in Middletown. Dr. Harwood has just completed a two year residency at the New York Post-Graduate Hospital after serving 4½ years with the Army Medical Corps.

The November meeting of the Central Medic Society was held on November 11, 1947. The scie tific program was a presentation of the Rh fact in obstetrics and pediatrics by members of the Ha ford Hospital staff in pathology and pediatrics. practical approach to this problem was given.

The December meeting of the Central Medic Society was held on December 9. Dr. Willia Scovill presented a paper on "Sympathectomy Hypertension." Methods of evaluation and resu were tabulated and a discussion of the "rice" di was included.

Weekly clinics of the Middlesex Hospital st for November to January were as follows:

November 5, Building Fund Committee repor November 19, presentation of influenzal memi gitis cases—Drs. Pilecki, Eilbergas, Grant, Foohe and Magnano. November 26, review of treatme of diseases of the thyroid—Dr. Vinci. December carcinoma of upper respiratory tract and the e and antrum—Dr. Chase. December 17, transurethr prostatecomy—Dr. Knight. January 7, bone tumo —Dr. Sweet.

House officers at the Middlesex Hospital chang on January 1. Dr. Sanford Harvey is awaitir orders from the Army Medical Corps and Dr. Jam Kidney is anticipating a residency in anesthesi Drs. Foohey and Eilbergas remain with us. D Edward Seinfeld started his service. Dr. Seinfeld h spent the last four years as a government physici at Point Barrow, Alaska.

Dr. Philip Schwartz, who is studying dermatolog at Cook County Hospital in Chicago spent the hol days with his family in Portland. He reports a ver interesting course of study.

The medical staff of the Middlesex Hospital h subscribed sufficient funds to assure the Great Middlesex Hospital of a modern and completel equipped laboratory. The Special Gifts Committe of the Building Fund is obtaining subscriptions no and at a later date the general canvass will take plac

At a special meeting of the Middlesex Count Medical Association held on January 5 the Societ accepted, with recommendations, the propose State Society "Medical Expense Insurance Plan."

New Haven

Harry E. Stewart, founder and president of th Junior College of Physical Therapy in New Haver died at his home on January 6. A native of Ne

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Careful consideration of all the methods advocated for the relief of pain during childbirth leads to the conclusion that local infiltration anesthesia combined with Demerol and scopolamine is one of the simplest, safest and most satisfactory methods for the average woman in the hands of the average practitioner.

For detailed discussion, see
Alfred C. Beck: Obstetrical Practice.
Baltimore, Williams and Wilkins Co.,
4th ed., 1947, page 403.

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Haven and graduate of Hillhouse, Yale University and the Yale School of Medicine, Class of 1910, Dr. Stewart was one of the leading organizers of physical therapy facilities during the first World War as a member of the Surgeon's General's Office of the United States Army.

Harry Goldstein was elected president of the New Haven Hearing League at the annual meeting January 8.

Brigadier General Harry H. Maynard, U. S. Army Medical Corps (Retired), died at St. Raphael's Hospital, New Haven, on January 8 after a brief illness. He served a lifetime in the Army medical service, specializing in recent years in aviation surgery.

Barnett Greenhouse of New Haven was one of the guest speakers at the mid-winter convention of the Connecticut Pharmaceutical Association. Dr. Greenhouse spoke on "The Use of Propyl Thiouracil in the Treatment of Hyperthyroidism."

Paul B. Kennedy has been reappointed school physician of Derby for another year.

Edward W. Foster was elected president of the Meriden Medical Society, succeeding Dr. Stephen L. Lirot, at the recent annual meeting of the organization. Raymond V. Quinlan was elected vice-president, Joseph A. Mekrut treasurer, and Max Caplan secretary.

The New Haven Medical Association recently named Harry A. Conte president, Wilder Tileston vice-president, Clement F. Batelli recording secretary, Frederick A. Wies financial secretary, and Joseph Petrelli treasurer.

The Waterbury Medical Association also held its annual meeting, electing the following officers: John H. Foster president, succeeding Christopher E. Dwyer; John J. Mullen vice-president, J. Harold Root treasurer, and Edo Pasetto secretary.

On January 27 a benefit party was held at the Waterbury Medical Society for the March of Dimes. About 200 attended, mostly from the Medical and Dental professions. A very enjoyable evening was spent with cards and dancing. The music was furnished by a local doctors' orchestra. Five hundred dollars was realized for the March of Dimes. Arrangements were made by Drs. Herbert Corbett and Vincent Shea.

The February speaker at the Waterbury Medical Society was Dr. William MacAusland of Boston, Massachusetts. His subject was "The Modern Treatments of Fractures." The Waterbury Medical Society has recently put out a mid-monthly bulletin of local news items, especially news of the monthly speaker. It is felt that this has greatly increased the attendance.

New London

Mario J. Albamonti of Norwich is taking a special three months course in obstetrics at Mar Hague Hospital, Jersey City, N. J.

Walter L. Douglass, who had practiced medicine in New London for about 25 years, died in Presto on January 21.

Windham

The Danielson Chamber of Commerce recently presented its first annual civic achievement award to Dr. Frank P. Todd, who has practiced medicine in that community for fifty-eight years.

A member of the visiting staff at the Day-Kimball Hospital, in Putnam, Dr. Todd received his medical degree from Boston University in 1889 and his license to practice in Connecticut in 1893. He is a member of the Connecticut State Medical Society, the American Medical Association, and local and county medical organizations.

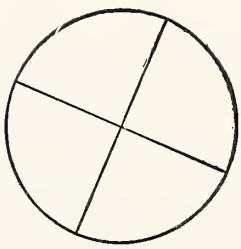
Dr. Morton Arnold, who has maintained an office at 781 Main Street in Willimantic for the past fourteen years, has moved to 29 North Street. The new location is much more commodious and will allow him to indulge himself much more extensively in the mysteries of his EEN&T practice. A EEN&T practice has been maintained at 781 Main Street for the past twenty-five or thirty years as Dr. Hendry was at this address before Dr. Arnold started practice. In the meantime Dr. F. C. Collier, now of South Coventry and Willimantic, has taken up the office at 781 Main Street for general practice.

It is reported that Dr. John Raymer, of Windham Center and Norwich, is making satisfactory progress in recovering from the injuries sustained in his recent automobile accident.

At a special meeting of the Windham County Medical Society held at the Nurses' Home of the Windham Hospital in Willimantic, January 13, it was the feeling of those present that the State Society should accept the proposed plan for prepaid insurance. The more vocal members expressed the thought that it was a favorable time to put such a plan into actuality and to amend it as time went on and experience dictated, rather than to hold off to perfect a plan before starting it and thus invite compulsory insurance.



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In overweight, most authorities strongly condemn thyroid therapy as irrational and potentially dangerous, except in those rare instances when an accompanying hypothyroidism has been definitely demonstrated.

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[1]Harris, S. C.; Ivy, A. C., and Searle, L. M.: THE MECHANISM OF AMPHETAMINE-INDUCED LOSS OF WEIGHT: A Consideration of the Theory of Hunger and Appetite, J.A.M.A. 134:1468 (Aug. 23) 1947.

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NEW BOOKS IN REVIEW

THE PSYCHO-ANALYTICAL APPROACH TO JUVENILE DELINQUENCY—Theory: Case Studies: Treatment. By Kate Friedlander, M.D. (Berlin), L.R.C.P., L.R.C.S. (Edin.), D.P.M. (London), Hon. Psychiatrist, Institute for the Scientific Treatment of Delinquency, Clinical Director, West Sussex Child Guidance Service. *New York: International Universities Press.* 1947. 296 pp. $5:50.

Reviewed by BENJAMIN H. GOTTESFELD

This book attempts to re-evaluate the Freudian concepts of childhood development from the oral, oedipal and anal levels and to correlate these findings with an interpretation of juvenile delinquency. The premises are based largely on the work of Anna Freud and D. Burlingham, especially as associated with the pregenital levels and the formulation and redirection of instinctual mechanisms. In addition the sum of the interpretative mechanisms are organized about the components of identification, narcissism and the displacement of early oedipal ties.

Although this book enables us to comprehend the juvenile dynamics from a psychoanalytic and physiological standpoint, it does not offer us a more adequate technique for the management of so-called juvenile delinquencies. It helps us interpret these phenomena without bringing into play the "antiquated moral concepts of right and wrong." In short, the descriptions of the latency period and the period of revolt are intimately woven into the comprehension of the delinquencies. Much of this work suggests a basis for correction in the earlier, formative years, but the values concerned indicate a sphere of sociological as well as emotional correction.

This book is an excellent summary of some of the more advanced interpretations of juvenile delinquency and is recommended to social workers and physicians interested in the problem.

PHYSIOLOGY OF MAN IN THE DESERT. By E. F. Adolph and Associates, Department of Physiology, University of Rochester, New York. *New York: Interscience Publishers, Inc.* 1947. 357 pp. $6.50.

Reviewed by DONALD H. BARRON

This monograph presents the data obtained in a study of the reactions of the human body to the stresses provided by life in hot climates with a restricted water supply: e.g., the desert and the sea; a study carried out as a wartime proje by the Rochester Desert Unit under the able leadership Prof. E. F. Adolph. The results collected in 357 well d signed "easy-to-read" pages are indispensable to all who a concerned with the maintenance and performance of m under these environmental conditions.

But the book is much more than a report of an investig tion. It is a superb treatise in physiology worthy of a pla alongside such classics as Haldane's "Respiration" and "T Respiratory Function of the Blood" by Barcroft, for t role of the sweat glands in temperature regulation and t water loss resulting from their activity provide unusu materials with which to illustrate the integrative aspects the adaptation of an organism to stress; unusual for th require in their collection and analysis no special or detail knowledge of chemistry and only the rudiments of physic Hence anyone who takes up this book is assured an insig into one of the basic problems of physiology with the con panionship of Professor Adolph's ordered thought. T concepts and viewpoints of one of the best minds in co temporary American physiology are presented with a vantage in the writings of his collaborators—who refle his teachings—as well as in his own chapters.

This excellent book deserves to be added to the librar however small that may be, of every physician, teacher an student interested in physiology. It is a book to be read an reread.

AMIABLE AUTOCRAT—A Biography of Dr. Oliv Wendell Holmes. By Eleanor M. Tilton. New Yor Henry Schuman. 1947. 470 pp. $5.

Reviewed by STANLEY B. WELD

Dr. Tilton's biography of the versatile poet-physicia lecturer may serve as a fitting companion to Clevelan Amory's "The Proper Bostonians." The appeal of the fo mer must be more extensive. Although a true Boston Bra min, Dr. Holmes' influence reached far beyond the confin of the "codfish aristocracy." His latest biographer in t "Amiable Autocrat" has brought to light new facts obtaine from sources not available during the lifetime of Dr. Holme son, the late Justice Holmes. These new sources have ma possible a picture of Dr. Holmes' early days in Cambridg and of his later years as a physician which have been lackin heretofore.

There is much in this volume to attract the New Englan physician. The Boston atmosphere is there. There too neighboring Cambridge with its gambrel-roofed homes an its apple trees, described by the historian John Fiske as th one place in Boston where no one "gives a damn who yo are." The Charles River, the Massachusetts General Ho



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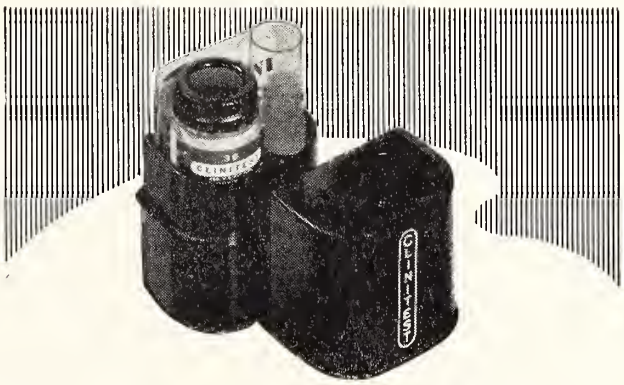
al, Harvard Medical School—all are there. How many ysicians started out for a career in some other field? iver Wendell Holmes had this experience and early re- aced Blackstone with Wistar's Anatomy. He philosophizes us: "If you would die fagged to death like a crow with e king birds after him, be a schoolmaster—if you would ax thin and savage like a half-fed spider, be a lawyer— you would go off like an opium-eater in love with your urving delusion, be a Doctor." His journey by stage to ovidence and thence by steamboat to New York en route Europe catches the eye. The love of fast horses to trans- ort him on his sick rounds till he was a menace to the destrian of Boston may recall memories. Difficulty obtain- g funds from his affectionate father to carry on his med- al studies in Europe requires no imagination to be under- ood by many a descendant of New England's first settlers. is just as true today as then that "a boy is worth his anure as much as a potato patch" and "it costs rather more do things than to talk about them."

Dr. Holmes' experiences as a lecturer included many a fficult journey and countless days away from his own eside. His success in this field is emphasized by his ographer equally with that attained from his magazine ticles. The "metallic tractors" of Dr. Elisha Perkins, the onnecticut Yankee, receive quick dispatch in his lecture on ledical Delusion. He compliments the Hartford poet, enry Howard Brownell, lawyer and secretary of Admiral arragut.

Over and above all else—his "Autocrat of the Breakfast able," his position as dean of Harvard Medical School, s contributions to the Atlantic Monthly, and his spirit of iendliness in the intimate group, The Saturday Club— ands out Dr. Holmes' drive against the scourge of puer- eral fever. In this he reached the peak of his fame. Dr. ilton is more successful in portraying O.W.H. as a physi- an and teacher than as an author. This is as it should be. lis contributions to medical science remain of far more alue than his poems, produced by request for many an ccasion. As professor of anatomy and dean of a medical chool fully a hundred years ago he expressed the opinion at the medical curriculum should be adapted to the needs f the general practitioner. Dr. Holmes was one of the first o introduce the microscope into this medical curriculum.

Dr. Eleanor M. Tilton has given us a volume both inter- sting and valuable. It is attractively bound and contains ine half-tone plates culled from many in existence. The uthor is an expert in the use of long sentences, adroitly rranged to hold the reader's interest. As in other of Henry ehuman's publications, source material is quoted in 8 oint type. The references for each chapter are grouped ogether at the end, an arrangement which has both advan- ages and disadvantages.

The atmosphere of 19th century Boston and Cambridge present. The quick step of the diminutive doctor at times an be heard. His sparkling wit and constant chit-chat are ever lacking as the story moves in and out of New England nd twice across the Atlantic. The author has been criticized or failing to make the subject emotionally real. Oliver Wen- ell Holmes was a member of one of Boston's First Families. Cold Roast Boston" remains a mystery to any but a Bostonian.



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NURSING IN MODERN SOCIETY. By Mary Ella Chayer, R.N., A.M., Associate Professor of Nursing Education, Teachers College, Columbia University. *New York: G. P. Putnam's Sons.* 1947. 288 pp. $4.

Reviewed by JEANNE S. MURPHY

At a period when nursing and all that it implies is under close scrutiny by its own practitioners and by the public and other professional groups with which it is closely associated, such a publication as this one is extremely timely. Although the title of the book would indicate that it has been written solely for nurses, there are many other groups of people who will find the points outlined here informative and helpful in understanding the problems of the present day nurse. Nurses, themselves, will find within its pages an aide for the re-evaluation of nursing and a blue print for its future development.

Miss Chayer has divided her book into three parts, the first of which discusses the impact of social forces upon nursing. She shows clearly that nursing does not nor cannot exist in a vacuum, for it is affected by the society of which it is a part and it, in turn, influences that society. As the social order changes, new patterns of nursing education are emerging, keeping pace with and attempting to meet the needs of the new order.

The second portion of the book deals with the influence of social forces upon the community health needs. We catch a glimpse of the broad present day concepts of public health and then are plunged into the significance of human behavior, child development and the problems of the modern parent. The first reaction of the reader is that the author has been so detailed in this area. On second thought, however, we recognize that our two major issues in health today deal with health education and with the guidance of our youth that they may attain a healthy adult state. If this is true, then we have spent our time wisely in an appraisal of the means of achieving sound health for our population. That other area of public health concern of which we are becoming increasingly conscious is our provisions for care of an aging populace. This problem, like the previous ones, has certain implications for nursing which are presented for the reader's persual.

Part three considers our place in the building of a better future through health education. A more thorough preparation of the workers and a better coordination of effort are probably the keys for sounder programs of health education and therefore a healthier population, locally, nationally and internationally. It is pointed out that as nurses we have a responsibility to further world health by participation in health organizations. The final chapter deals with the principles of professional service, enumerating those areas in which nursing has strength and methods by which we can improve our own service.

The reader, aware of the problems of nursing today, is bound to find some controversial issues in these pages. Nursing, itself, is searching for an answer to these problems and it is hoped that an objective presentation of them will evoke serious thought and perhaps some solutions to them that will enhance our value to society. There is a wealth of material in the bibliography, indicating that the author has read widely to accumulate ideas from many sources. The book is well written, interesting, informative and thoug provoking.

THE CHALLENGE OF POLIO. By Roland H. Ber New York: The Dial Press. 1946. 208 pp. $2.50.

Reviewed by STANLEY B. WELD

Ever since the major epidemic of infantile paralysis i 1916 research has been carried on in this country and abroa in an effort to determine the cause, the prevention, and th cure of this disease. At first this research was financed b individuals, but since the formation of The National Foun dation for Infantile Paralysis in 1938 the American publi has had the opportunity to carry out a vast program c research through this organization.

The author of this book recounts in an interesting manne the entire story of anterior poliomyelitis since the first siz able epidemic in this country in 1894. Franklin D. Roosevelt fight with the dread disease and final triumph are recounte The research program is epitomized. In this the reader wi note the prominence played by two Yale scientists, Dr. Joh R. Paul and the late Dr. James R. Trask. Sister Kenny theory of treatment and her technique is outlined and it conflict with the known pathology of the diseases clearl outlined.

The final chapter contains a summary of present da knowledge of the disease and points out the missing link in prevention and prognosis. As the author states in conclu sion, "treatment, effective as it is, merely relieves symptom and salvages damaged muscles. It is not the final answer t the challenge of polio. Only in the laboratories of medica scientists still seeking the absolute cure or prevention, ca the challenge of polio finally be answered."

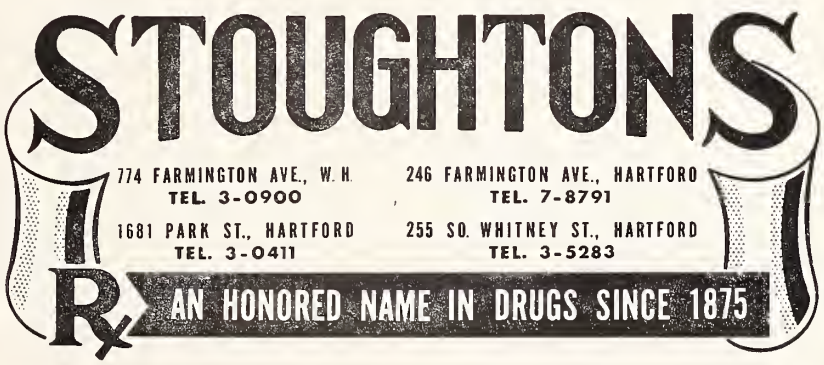
This is an excellent book, written in a style both clea and interesting. The layman can understand its content, th physician will profit by the information it contains.

400 YEARS OF A DOCTOR'S LIFE. Collected and Ar ranged by George Rosen, M.D. and *Beate Caspari-Rosen* M.D. *New York: Henry Schuman.* 1947. 429 pp. $5.

Reviewed by STANLEY B. WELD

It is difficult to become enthusiastic over this Reader' Digest type of biography. The only excuse for such a volum is that some busy lecturer or writer might wish to refe to it as one would to a book of familiar quotations. Book stands have become deluged with digests of everything an now we have, not a digest in the case of most of the char acters, but more nearly a series of biopsies from poetry letters and autobiographies of famous physicians.

The authors have chosen 85 physicians and extracted fron their lives samples fitting into one or more of 10 classifica tions: early years; school days; the medical student; th practice of medicine; scientist, scholar, teacher; the docto marries; the doctor as a patient; the doctor goes to war writing and politics; and reflections on life and death. These physicians represent many nationalities. The majority live during the 18th or 19th centuries, but a few were living as early as the 16th century, and less than a score are stil alive.



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To J. Marion Sims goes the honor of being selected for glimpses of his life through the early years, as a practising physician, a husband and a patient. No other portrait is as complete in this volume. Connecticut is represented by Horace Wells and Alice Hamilton, each with three different portraits from their lives. The names of Oliver Wendell Holmes, Harvey Cushing, Walter Cannon and Hans Zinsser should be familiar to all; likewise William Beaumont, Edward L. Trudeau, William Osler and Henry Sigerist. To fill in the section of the volume entitled "The Doctor Goes to War," the authors found it necessary to draw upon a group of almost entirely new characters.

This volume is bound in Schuman's usual attractive style. Each "biopsy" contains a brief introductory outline of the character's life. The authors have done a very commendable job but an autobiography to be appreciated should be read in its entirety. Time may prove the error of this statement. This is a new venture in medical history, a series of snapshots rather than full length portraits.

PRACTICAL CHILD GUIDANCE AND MENTAL HYGIENE. By Samuel Kahn, M.D., PH.D., Adjunct Professor of Psychology and Psychiatry at Long Island University; formerly Professor of Neurology and Psychiatry at Georgetown and George Washington Universities; Chief Psychiatrist, New Jersey and Delaware Induction Boards for the United States Army; and *Grace Kirsten*, A.B., formerly with the New York City Department of Education and Lecturer on Child Guidance; and *May Elish March*, A.B., M.A., formerly a teacher in the New York City High Schools. *Boston: Meador Publishing Company*. 1947. 285 pp. $4.

Reviewed by CATHERINE S. AMATRUDA

To fill any need in the field of child guidance, a new book would have to be distinguished by excellencies of presentation, significant new material, or a valuable new viewpoint. This book has none of these virtues.

Practical Child Guidance is written in question and answer form, the questions presumably having been submitted by parents of actual children. The objections to this form of presentation are numerous. It is inevitable that specific questions (and answers) are difficult to find or that they may not even be included; there are many curious omissions and almost any answer pertaining to the problem behavior of a given child seems too brief, too pat; too little is given of the child's circumstances for the answer given to be more than one of many possible answers. The writing is endlessly repetitious and often inelegant.

This book makes some superficial pretensions to a psychoanalytic approach to children's problems but on the whole the advice is either naive, "Tell him he's too nice and smart a boy to do a thing like that," or dogmatically authoritarian, "Punish him." This sort of advice is reverently described as Child Guidance, with capital letters. When a psychoanalytic reference is made, "Your boy is already too attached to his mother and has an Oedipus complex," no explanation is offered; it is simply assumed that the reader knows what an Oedipus complex is. Occasionally referral to a Child Guidance specialist or expert is prescribed; the professional reader might want to know how this expert would handle the problem, but nothing of his method is revealed.

The most serious indictment against this book, however, is its repeated, outspoken advocacy of whipping. The heights of bad counsel as well as inconsistency are reached in the response to the question of a three year old child who wakes crying six or seven times a night (the answer is quoted in full, italics the reviewers): "A. It is not normal for a child to act this way. Either she is sick and in pain or she has been spoiled by too much fondling, by keeping her in the same bed with her parents, or by overstimulating her before she retires. You will have to decide what is causing her to become emotionally upset and you will gradually have to re-educate her. Be sure that she is free from pain and that you are no longer spoiling, pampering, overprotecting and overstimulating her. Gradually, in her own room and with no lights, she will stop her crying spells. You may have to go into her room once or twice to tell her to stop crying because she is a big girl and knows better. Be sure that you remain completely calm and unemotional throughout. If she does not stop crying, *promise her a whipping*. If she continues to cry, *give her a good whipping*. This may have to be *repeated a second or a third time* but no more than that. Usually if the child is properly handled, no licking will be necessary, especially if the parents remain pleasant, encouraging and unemotional. *When a licking is necessary*, the situation has already become abnormal because of bad child guidance in the home. *The parents are either ignorant or neglectful; and they deserve the licking.*"

If this book were simply poor; it could be dismissed with very few words. It is reviewed at such length because it is bad and potentially harmful.

FUNDAMENTALS OF IMMUNOLOGY. (Second Edition.) By *William C. Boyd*, PH.D., Associate Professor of Biochemistry, Boston University School of Medicine. *New York: Interscience Publishers, Inc.* 1947. 519 pp. 50 illustrations. $6.

Reviewed by MORRIS TAGER

Although Boyd's second edition of "Fundamentals of Immunology" has been considerably expanded and revised, the basic approach and point of view of the earlier edition remains unchanged. It is perhaps significant that the author, a distinguished contributor to immunology, is a chemist, and the vital influence of chemistry on the progress of immunology finds due expression in this volume. Dr. Boyd has directed his book primarily to the student and the research worker, considering such phases of the field as the general principles of immunity, antibodies, antigens, hypersensitivity, and practical uses of immunology. Much of recent advance is given proper consideration, such as that pertaining to the blood groups; some, however, notably the work on the reaction of lymphocytes to antibodies, is too briefly dismissed. The practicing physician interested in a better understanding of the basic concepts of immunology would find this work rewarding. However, it does not attempt to offer any extensive consideration of applied immunology, an effort which might well serve as a companion volume to this work.

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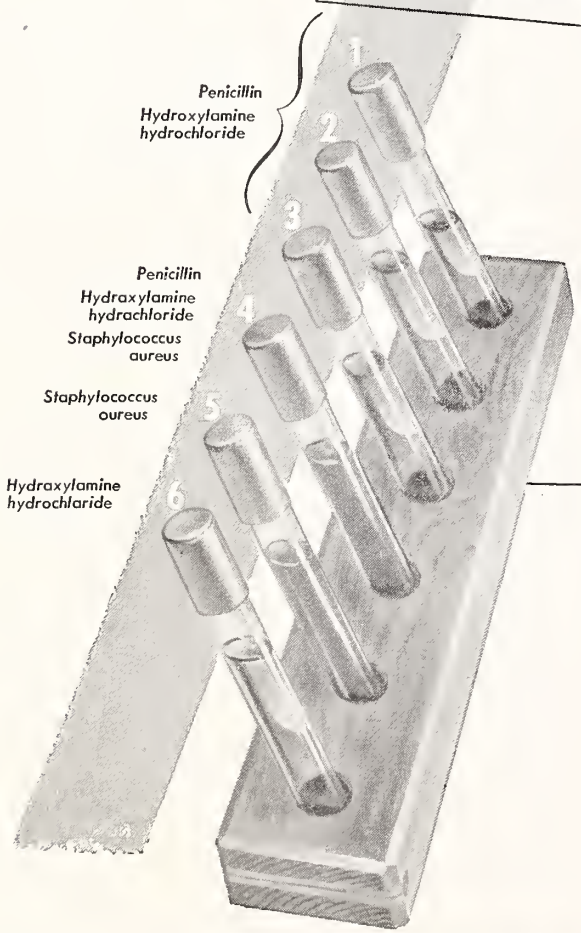
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EAST VIEW OF THE COURT HOUSE, CHURCH AND JAIL, FAIRFIELD

J. W. Barber 1838

Uncoway or ancient Fairfield was "discovered" by the Yankee pioneers in 1637 when under Roger Ludlowe a band of Connecticut troops pursued the Pequots in their flight from Mystic Fort to their annihilation in the Great Swamp Fight (Sasqua Swamp, between Fairfield and Saugatuck). Later the Sasco Indians gave a quit claim to the land for "thirty coats, two yards apiece of cloth and the same in wampum." During the Revolution under General Tyron the British devastated the town by burning probably 200 houses and barns, and two churches and all public buildings. Later, in compensation for these severe losses, the sufferers and their heirs were granted 500,000 acres of land owned by Connecticut in Ohio. This area was known as the Fire Lands. Among the men of renown whose names are associated with Fairfield were the two Aaron Burr's, the father one time president of Princeton College, and the son vice-president of the United States, Timothy Dwight, theologian and president of Yale College, Gold Selleck Silliman, a brigadier general of the Revolution, Benjamin Silliman, "the Nestor of American Science," and Sereno Dwight, president of Hamilton College. On Unquowa Road in the rear of Ludlowe High School is the restored Powder House built originally in 1812 of stone taken from the former home of Dr. Laborie, surgeon and preacher, noted for his missionary work with the Indians.

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XII APRIL, 1948 No. 4

156TH ANNUAL MEETING
of the
Connecticut State Medical Society
April 27, 28 and 29, 1948

PROGRAM COMMITTEE

SAMUEL C. HARVEY, *New Haven*, Chairman
CARL E. JOHNSON, *New Haven*
MAURICE T. ROOT, *Hartford*
JOHN F. FULTON, *New Haven*, Associate Member

LOCAL COMMITTEE ON ARRANGEMENTS

JOSEPH H. HOWARD, *Bridgeport*, Chairman
GEORGE A. BUCKHOUT, *Bridgeport*
JOHN E. BUCKLEY, *Bridgeport*
WILLIAM H. CURLEY, *Bridgeport*
MAXON H. EDDY, *Bridgeport*

Tuesday, April 27

ANNUAL MEETING OF THE HOUSE OF DELEGATES

HOTEL STRATFIELD, 1241 Main Street, Bridgeport
JAMES R. MILLER, *presiding*

10:00 BUSINESS SESSION

1:00 LUNCHEON FOR MEMBERS OF THE HOUSE, OFFICERS AND GUESTS

2:00 THE MEETING RECONVENES—REPORTS AND ELECTION OF OFFICERS AND COMMITTEES

ANNUAL DINNER OF THE COUNCIL

HOTEL STRATFIELD

7:00 ANNUAL DINNER OF THE COUNCIL, the Program Committee, the Local Committee on Arrangements and Guests

PROGRAM

Main Auditorium of the Roger Ludlowe High School, Unquowa Road, Fairfield

Wednesday, April 28

James R. Miller, *presiding*

9:00 Registration

9:20 Motion Picture

9:45 Call to Order

Address of Welcome—President of the Fairfield County Medical Association

10:00 Some Harmful Effects of Irradiation

W. Edward Chamberlain, *Professor of Radiology, Temple University Medical School; Head of the Department of Radiology, Temple University Hospital*

10:30 What the General Practitioner Should Know About Dermatology

George Clinton Andrews, *Associate Professor of Dermatology, Columbia University College of Physicians and Surgeons; Attending Dermatologist, Presbyterian Hospital*

11:00 Motion Picture

Joseph H. Howard, *presiding*

11:15 Head Trauma

Jefferson Browder, *Professor of Clinical Surgery, Long Island College of Medicine; Chief of Neurosurgery, Kings County Hospital*

11:45 Integration of Anesthesiology in Medicine

Edward B. Tuohy, *Professor of Anesthesiology, Georgetown University Medical Center; Director of the Department of Anesthesia, Georgetown University Hosptal*

12:15 Practical Methods of Immunization

John E. Gordon, *Professor of Epidemiology, Harvard School of Public Health*

12:45 Luncheon—Cafeteria of the High School

2:15 Motion Picture

Carl E. Johnson, *presiding*

2:30 Symposium on Gynecology—Emil Novak, Chairman

1. Office Gynecology

Emil Novak, *Assistant Professor of Gynecology, Johns Hopkins University School of Medicine; Gynecologist-in-Chief, St. Agnes Hospital*

2. Management of Functional Menstrual and Reproductive Disorders

Jacob Hoffman, *Instructor in Gynecological Pathology, Jefferson Medical College; Associate in Gynecology, Jefferson Hospital*

3. The Vaginal Smear and the Surface-Biopsy Method: Aids to Diagnosis in Gynecology

J. Ernest Ayre, *Assistant Gynecologist and Obstetrician, Royal Victoria Hospital, McGill University, Montreal*

3:30 Motion Picture

3:45 Panel Discussion—Doctors Novak, Hoffman, Ayre, Hugh K. Miller, Stamford

7:00 Annual Dinner of the Society, Hotel Stratfield

His Excellency James C. Shannon, *Governor of Connecticut*

Edward L. Bortz, *President of the American Medical Association*

Entertainment Michael MacDougall, *the Card Detective*

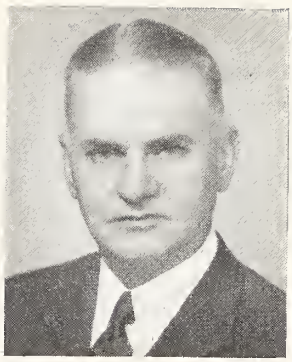
Reservation cards for the Annual Dinner will be included in the final program which will be distributed to all members



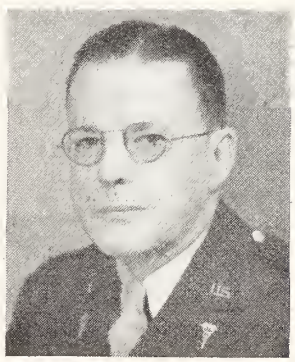
W. Edward Chamberlain, University of California, M.D., 1916; World War I, Lieutenant (j.g.) U. S. Navy, roentgenologist; professor of medicine, in charge of the Department of Radiology at the Medical School of Leland-Stanford Junior University in San Francisco, 1920-30; professor of radiology, Medical School of Temple University, 1930 to date; past president of American College of Radiology and of the Philadelphia Roentgen Ray Society; special consultant to the Division of Tuberculosis Control, U.S.P.H.S.; chairman of the x-ray surveys committee, Philadelphia Tuberculosis and Health Association; member of the subcommittee on tuberculosis of the committee on medicine, National Research Council; chairman of the committee on radiology in public health, American College of Radiology; consultant in the Department of Medical Research of Brookhaven National Laboratory.



George Clinton Andrews, Cornell University, A.B., 1912; College of Physicians and Surgeons, Columbia University, M.D., 1918; associate clinical professor, College of Physicians and Surgeons; chief of clinic, Department of Dermatology, Vanderbilt Clinic, chief of Dermatology Clinic, Roosevelt Hospital; attending dermatologist at the Presbyterian and Roosevelt Hospitals; perhaps best known for his textbook "Diseases of the Skin," published by the W. B. Saunders Company of Philadelphia, which is now in its third edition.



Jefferson Browder, Johns Hopkins University, M.D., 1920; professor of clinical surgery, Long Island College of Medicine; attending neurosurgeon, Brooklyn Hospital and chief of neurosurgery, Kings County Hospital; Diplomate American Board of Neurological Surgery; Diplomate American Board of Surgery.



John E. Gordon, Rush Medical College, University of Chicago, M.D.; instructor in bacteriology, University of Chicago; associate professor of bacteriology, University of Western Ontario, Canada; medical director, Division of Communicable Diseases, Herman Kiefer Hospital, Detroit, 1927-33; field director, Rockefeller Foundation, 1933-38, including three year residence in Rumania conducting epidemiologic investigations in streptococcal infections; director, American Red Cross-Harvard Field Hospital Unit, Salisbury, England, 1940-42; Colonel, Medical Corps, U. S. Army, serving as chief of preventive medicine, European Theater of Operations, date as consultant in Pacific Theater, 1942-46; professor of preventive medicine and epidemiology, Harvard School of Public Health since 1938; consultant to the Surgeon General, U. S. Army and to the Surgeon General, U.S.P.H.S.; numerous contributions to medical and scientific journals, many in the field of streptococcal and meningococcal infections.

Thursday, April 29

SAMUEL C. HARVEY, *presiding*

9:00 REGISTRATION

9:20 MOTION PICTURE

9:45 DRUGS AND DYNAMICS IN THE ENTERIC CANAL
William T. Salter, *Chairman, Department of Pharmacology, Yale University School of Medicine; Pharmacy Committee, Grace-New Haven Community Hospital*

10:15 DIFFERENTIAL DIAGNOSIS OF CORONARY ARTERY DISEASE
H. M. Marvin, *Associate Clinical Professor of Medicine, Yale University School of Medicine; Attending Physician, Grace-New Haven Community Hospital*

10:45 MOTION PICTURE

THOMAS P. MURDOCK, *presiding*

11:00 INFECTIOUS HEPATITIS
Joseph Stokes, Jr., *Professor of Pediatrics, University of Pennsylvania School of Medicine; Physician-in-Chief and Medical Director, Children's Hospital of Philadelphia*

11:30 SOME ASPECTS OF FLUID, ELECTROLYTE AND PROTEIN BALANCE IN THE DEHYDRATED PATIENT
Charles R. Drew, *Professor of Surgery, Howard University College of Medicine; Chief Surgeon, Freedman's Hospital*

12:00 CONVOCATION OF THE SOCIETY
ADDRESS OF THE RETIRING PRESIDENT, JAMES R. MILLER
INTRODUCTION OF THE PRESIDENT-ELECT AND OFFICERS FOR 1948-1949

12:45 LUNCHEON—Cafeteria of the High School

2:15 MOTION PICTURE

2:30 SYMPOSIUM ON ALCOHOLISM
Chairman, Charles T. Bingham, *Clinical Instructor in Medicine, Yale University School of Medicine; Member, Connecticut Commission on Alcoholism*

1. SOCIOLOGICAL ASPECTS OF ALCOHOLISM
Selden D. Bacon, *Associate Professor of Sociology, Yale University; Chairman, Connecticut Commission on Alcoholism*

2. THE ALCOHOLIC PERSONALITY FROM THE PSYCHIATRIC POINT OF VIEW
Harry M. Tiebout, *Physician-in-Charge, Blythewood Sanatorium*

3. ALCOHOLISM AS A MEDICAL PROBLEM
Howard W. Haggard, *Director, Laboratory of Applied Psysiology, Yale University*

3:30 MOTION PICTURE

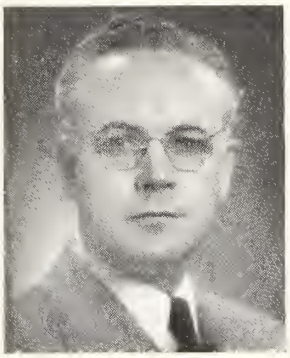
3:45 PANEL DISCUSSION—Mr. Bacon, Doctors Bingham, Haggard, Tiebout and Benjamin H. Gottesfeld, Hartford



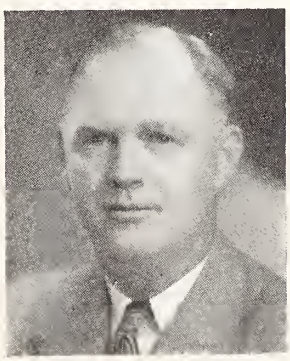
Emil Novak, Loyola University, A.B., 1902; University of Maryland, M.D., 1904; associate, later associate professor of gynecology, Baltimore Medical College, 1905-09, and associate professor of gynecology at College of Physicians and Surgeons until 1915; associate in gynecology at Johns Hopkins since 1915; associate professor of obstetrics, University of Maryland since 1925; director of Passano Foundation for Medical Research; fellow of American College of Surgeons; diplomate of American Board of Obstetrics and Gynecology; member of American Gynecological Society (past vice-president); author of about 300 articles in his special field.



Jacob Hoffman, University of Pennsylvania, A.B.; Jefferson Medical College, M.D., 1925; post-graduate work on Fellowship in Berlin, Germany under Professors Robert Meyer and Bernard Zondek; formerly research fellow in endocrinology, chief of endocrine clinic, and gynecologic pathologist; now associate in gynecology and instructor of gynecologic pathology at Jefferson Medical College and Hospital; author of *Female Endocrinology*, published in 1944 by W. B. Saunders Company.



J. Ernest Ayre, University of Alberta, M.D., 1936; post-graduate work at Royal Northern Hospital, London, England, 1939, Royal Victoria Hospital and St. Mary's Hospital, Montreal, Canada, 1939-41; assistant gynecologic pathologist, Royal Victoria Hospital, 1941-45; director, Department of Gyne-cytology, Women's Pavilion, Royal Victoria Hospital, McGill University, Montreal; assistant gynecologist and obstetrician, Royal Victoria Hospital, 1942-48; lecturer in gynecology, McGill University, 1942-48; Fellow of Society of Gynecologists and Obstetricians of Canada, honorary member of the South Atlantic Association of Obstetricians and Gynecologists, research member of the Hodgkin's Disease Research Foundation, Inc., New York; elected as honorary fellow of the American Medical Association in 1947; director, Cytology Centre for the Prevention of Cancer, Montreal; author of over 30 medical publications on cancer, gynecology, pathology and cytology.



Edward Boyce Tuohy, University of Minnesota, B.S., 1929; University of Pennsylvania, M.D., 1932; Fellow, Mayo Foundation, Rochester, Minnesota, 1933-35; M.S in Anesthesiology, 1936; Major, Army Medical Corps, 1942-45; consultant on staff of Mayo Clinic, Mayo Foundation, 1935-47; professor of anesthesiology, Georgetown University School of Medicine, July 1947; Diplomate American Board of Anesthesiology, 1939.

MEETINGS OF GUEST ORGANIZATIONS AND SECTIONS OF THE SOCIETY

Wednesday, April 28

WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

The Annual Meeting of the Woman's Auxiliary to the Society will be held on Wednesday, April 28, at the Brooklawn Country Club, Bridgeport, beginning with luncheon at 1:00 o'clock. There will be a guest speaker following luncheon and a business meeting at 3:00 o'clock.

2:30

ANESTHESIA

1. Business Meeting
2. Scientific Session
   - A. Address of the President
     Stevens J. Martin, *St. Francis Hospital, Hartford*
   - B. A New Method of Parenteral Medication and Anesthesia with the Hypospray
     Edward B. Tuohy, *Professor of Anesthesiology, Georgetown University Medical Center*
   - C. Peripheral versus Central Depression in Anesthesia
     William T. Salter, *Chairman, Department of Pharmacology, Yale University School of Medicine*

AVIATION MEDICINE

The Section has planned a discussion meeting without guest speakers.

DERMATOLOGY AND SYPHILOLOGY

Possible Medical Prevention of Cancer in Chronic Radio-Dermatitis

George Clinton Andrews, *Associate Professor of Dermatology, Columbia University College of Physicians and Surgeons*

Discussion will be opened by Ellwood C. Weise, *Bridgeport,* E. Myles Standish, *Hartford,* and Neville Kirsch, *Hartford*

INDUSTRIAL HEALTH

The Diagnosis of Disease Arising from Occupation: Some Special Features and Pitfalls

Lemuel C. McGee, *Medical Director, Hercules Powder Company, Wilmington, Delaware*

NEUROLOGY AND PSYCHIATRY

Program arrangements have not been completed

OBSTETRICS AND GYNECOLOGY

The Section will meet with the Symposium on Office Gynecology and will hold a business meeting following the symposium

HEZEKIAH BEARDSLEY PEDIATRIC CLUB

Orthopedic Problems of Childhood

William T. Green, *Orthopedic Surgeon-in-Chief, Children's Hospital, Boston*

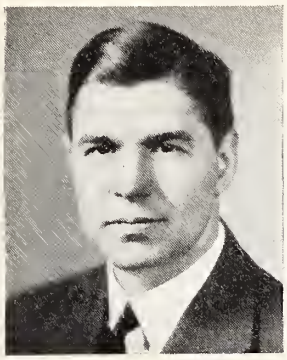
RADIOLOGY

Application of Atomic Energy in Biology and Medicine

W. Edward Chamberlain, *Professor of Radiology, Temple University Medical School*

ASSOCIATION OF MEDICAL EXAMINERS OF CONNECTICUT

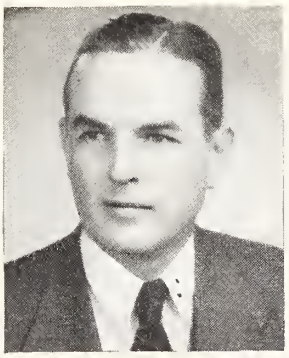
Program arrangements have not been completed



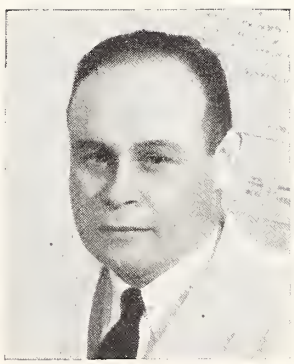
William T. Salter, Harvard University, B.A., 1922, M.D., 1925; Yale University, M.A., 1941; medical resident and research fellow, Mass. General Hospital, 1927-28; at Harvard University, Moseley traveling fellow, 1928-29; research fellow in medicine, 1929-32; tutor, biochemical sciences, 1929-39; associate physician, Huntington Memorial Hosiptal, 1929-39; junior associate in medicine, Peter Bent Brigham Hospital, 1932-36, becoming associate in medicine, 1937; research fellow in biochemistry, Harvard Cancer Commission, 1929-39; at Harvard Medical School, faculty instructor in medicine, 1932-34; assistant professor of medicine, 1934-41; associate physician, Thorndike Memorial Laboratory, 1939-41; junior visiting physician, Boston City Hospital, 1939-41; professor of pharmacology, Yale University School of Medicine since 1941; author of *The Endocrine Function in Iodine,* 1940, and over 65 articles in various medical journals.



H. M. Marvin, Harvard Medical School, M.D., 1918; district medical officer with Near East Relief, Armenia, 1919-20; assistant in medicine, Massachusetts General Hospital and Harvard Medical School, 1920-21; instructor, assistant professor, assistant clinical professor, Yale University School of Medicine, associate clinical professor of medicine, Yale University School of Medicine since 1921; Guggenheim Memorial Fellow, with Sir Thomas Lewis, London, 1926-27; attending physician, New Haven Hospital and Dispensary; consulting cardiologist to several hospitals; Editorial Board, *American Heart Journal* since 1933; executive secretary, American Heart Association since 1932; chairman, American Council on Rheumatic Fever, 1947-48.



Joseph Stokes, Jr., University of Pennsylvania Medical School, M.D., 1920; instructor in pediatrics, associate in pediatrics, William H. Bennett assistant professor, assistant professor in pediatrics, associate professor, William H. Bennett professor of pediatrics, 1924 to date; associate physician in chief, physician in chief, Children's Hospital, 1936 to date; director pediatric service, Abington Hospital, 1930-39; chief of pediatric service, Hospital of University of Pennsylvania since 1939; director, Commission on Measles and Mumps of Board for the Investigation and Control of Epidemic Diseases; consultant to surgeon general, U. S. Army; chairman joint committee on public health and preventive medicine, College of Physicians and Philadelphia County Medical Society since 1938.



Charles Richard Drew, Amherst College, A.B., 1926; McGill University, M.D. and C.M. (Master of Surgery), 1933; Columbia University, MED. D. SC., June 1940; instructor in pathology, assistant in surgery, instructor in surgery, assistant professor of surgery, professor of surgery, Howard University, College of Medicine, 1935-41; resident in surgery, assistant surgeon, surgeon, chief surgeon, Freedmen's Hospital, 1936 to date; general education board fellow in surgery, Columbia University, 1938-39; resident in surgery, Presbyterian Hospital, New York City, 1939-40; in charge of blood plasma and blood procurement for several organizations; chairman, surgical section, National Medical Society, August 1944 vice president, American Soviet Medical Society, November 1944.

Thursday, April 29

2:30

CONNECTICUT ALLERGY SOCIETY

Round table discussion on The Antihistaminics

EYE, EAR, NOSE AND THROAT

Pathology of the Eye, Ear, Nose and Throat

Andrew A. Eggston, *Pathologist, Manhattan Eye, Ear, Nose and Throat Hospital*

ORTHOPEDICS

1. The Cerebral Palsies
   Russell V. Fuldner, *New Haven*
2. Rheumatoid Arthritis
   Dennis S. O'Connor, *New Haven*
3. Early Ambulation in Orthopedic Surgery
   Donald B. Wells, *Hartford*

PHYSICAL THERAPY

A meeting will be held for the purpose of reorganization of the Section but there will be no speakers

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

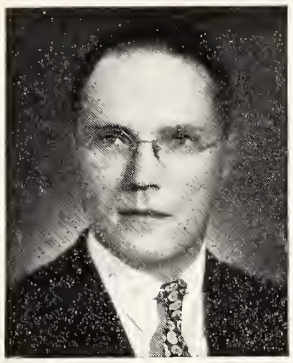
Program arrangements have not been completed

The following guest organizations will meet with the Society on Thursday, April 29, but they have not yet furnished details of their programs:

Connecticut Branch, American Association of Medical Social Workers
Connecticut Occupational Therapy Society
Connecticut Chapter, Association of Medical Record Librarians
Connecticut Branch, American Association of Physiotherapists
Women's Medical Society of Connecticut

Technical Exhibits

Space Number	*Firm*	*Location*
1 and 7	Surgeons and Physicians Supply Company	Boston
2 and 3	Professional Equipment Company	New Haven
4	Spencer, Inc.	New Haven
5	E. F. Mahady Company	Boston
6	Burroughs Wellcome and Co., Inc. (U. S. A.)	New York
8 and 9	Brewer and Company, Inc.	Worcester
10	Doho Chemical Corporation	New York
11	Ciba Pharameutical Products, Inc.	New Jersey
12	Philip Morris and Company, Inc.	New Yor
13	White Laboratories, Inc.	Newar
14	H. W. Kinney and Sons, Inc.	Indian
15	Mead Johnson and Company	Evansvill
16	Nestle's Milk Products, Inc.	New Yor
17	Van Pelt and Brown, Inc.	Richmon
18	G. D. Searle and Company	Chicag
19	E. L. Washburn and Company	New Have
20	E. R. Squibb and Sons	New Yor
21	Wm. P. Poythress and Co., Inc.	Richmon
22	D. G. Stoughton Company	Hartfor
23	Smith, Kline, and French Laboratories	Philadelphi



Selden D. Bacon, Yale, B.A., 1931; Yale M.A. (government), 1939; Yale PH..D. (sociology), 1939. Social Science Research Council field fellow, 1936-7; Instructor in sociology, Pennsylvania State College, 1937-1939, associate professor of sociology, Yale University, 1939 to date; associate editor, *Quarterly Journal of Studies on Alcohol;* Board of Directors, Connecticut Prison Association; treasurer-secretary, National Committee for Education on Alcoholism; vice-president, Social Worker's Club of New Haven; sociologist of Section of Alcohol Studies of the Laboratory of Applied Physiology, Yale University; Board of Directors, Council of Social Agencies of New Haven; fellow of Branford College; chairman, Connecticut Commission on Alcoholism; lecturer, Yale Summer School of Alcohol Studies; author of *Drunkeness in Wartime Connecticut* (1943); *Sociology and the Problems of Alcohol* (1944); *Inebriety, Social Integration and Marriage* (1945); *Alcoholism: A Major Social Problem* (1946).





Harry Morgan Tiebout, Wesleyan University, B.S., 1917; Johns Hopkins Medical School, M.D., 1921; assistant physician, Bloomingdale Hospital, White Plains, N. Y., 1922-24; fellow child guidance, National Committee for Mental Hygiene, 1924-25; psychiatrist for several child guidance clinics, 1925-35; assistant professor psychiatry, Cornell Medical School, 1932-35; physician-in-charge, Blythewood Sanitarium, 1935 to date; psychiatrist, Sarah Lawrence College 1935-47; lecturer, summer school of Section on Alcohol Studies, Yale University; secretary-treasurer, New York Psychiatric Soicety; past president, New York Society for Psychopathology and Psychotherapy; past secretary-treasurer and president, Connecticut Society for Psychiatry and Neurology; chairman of Advisory Committee of National Committee for Education on Alcoholism; author of numerous articles on the problem of alcoholism.

Howard W. Haggard, Yale University, PH.B., 1914, M.D., 1917; physiologist, U. S. Bureau of Mines, 1917; consulting physiologist, 1919-23; instructor in physiology, 1919-23, and assistant professor, 1922-26, Yale Medical School; transferred to Sheffield Scientific School, Dept. of Applied Physiology, Yale University, 1923; associate professor since 1926; author of several books on physiology and medical history.

PREFRONTAL LOBOTOMY: A PRELIMINARY REPORT

JANE E. OLTMAN, M.D., BERNARD S. BRODY, M.D., and SAMUEL FRIEDMAN, M.D., *Newto*

Dr. Oltman. *Senior Psychiatrist, Fairfield State Hospital*

Dr. Brody. *Consultant in Neuro-Surgery, Fairfield State Hospital*

Dr. Friedman. *Clinical Director, Fairfield State Hospital*

PREFRONTAL lobotomy was introduced in this country more than a decade ago by Freeman and Watts.[1] It has gradually gained acceptance as a valuable therapeutic procedure in certain types of mental illness. During this period there have been no reports, save for a review of the literature,[2] by investigators in this state concerning the results and efficacy of prefrontal lobotomy. In view of this, it was felt that a preliminary report from a Connecticut hospital concerning its initial results with this relatively new approach to certain problems of mental disease might be of interest at this time.

Prefrontal lobotomy was initiated at the Fairfield State Hospital in May, 1946. Thus far, 107 patients have undergone the operation. All operations were performed by one of the authors (B.S.B.) using the Lyerly[3] method or slight modifications thereof. Our patients have now been observed postoperatively for periods ranging from 2 to 15 months.

Our operative material was composed almost entirely of individuals suffering from chronic mental illness whose prognosis was regarded as extremely unfavorable. From the diagnostic standpoint the group was classified as follows:

TABLE 1

DIAGNOSTIC CLASSIFICATION OF 107 LOBOTOMY PATIENTS

DIAGNOSIS		NO. OF PATIENTS	PERCENTAGE OF TOTAL
1. Dementia praecox		91	85.0%
Simple	5		
Hebephrenic	21		
Catatonic	17		
Paranoid	33		
Mixed or undet.	15		
2. Affective disorders		8	7.5%
Manic-depressive	5		
Involutional	3		
3. Paranoid condition		4	3.7%
4. Others		4	3.7%

These data serve to crystallize the fact that schi phrenia represents the major problem in the sph of chronic mental illness and that this disease is a profound therapeutic enigma.

Table 2 summarizes the duration of mental illn in our cases prior to operation.

TABLE 2

DURATION OF MENTAL ILLNESS IN 107 LOBOTOMY PATIENTS P TO OPERATION

DURATION	NO. OF PATIENTS	PERCENT OF TOT
Under 1 year	2	1.9%
1-2 years	7	6.5%
2-5 years	22	20.6%
5-10 years	49	45.8%
Over 10 years	27	25.2%

It is obvious that over 70 per cent of the gro had been mentally ill for more than five years pr to operation. The chronicity of illness in this gro of patients and the poor prognosis that implici accompanies such chronicity are readily appare

The group ranged in age from 18 to 64. Fem patients constituted the great majority, in the ra of 78 women (73 per cent) to 29 men (27 per cen The reasons for this disproportion were sever chronically ill female patients seem to offer great problems from the standpoint of general manag ment as they are usually more disturbed; disturb female patients almost invariably outnumber d turbed males; and finally, our own cumulative exp rience, as well as that of other investigators, inc cated that the disturbed, aggressive, hostile group of which females formed the major fraction in t hospital—constituted the most favorable subjects f lobotomy. Approximately 50 per cent of our patien had been treated previously by one or more typ of shock therapy without significant long-term in provement. Many others did not receive shock insulin treatment because their illness and hospital zation had antedated the use of these therapeut advances, and the later advent of shock treatme found these individuals hopeless subjects for suc therapy.

The clinical results following prefrontal lobotom have been tabulated in the following terms: muc

proved, improved, slightly improved and unimproved. It is obviously impossible to record completely the criteria of these classifications, as they are measurable chiefly in terms of clinical impressions and observations. It can be stated that any changes in patients' behavior were evaluated in as objective and critical a manner as possible. The results are summarized in Table 3.

Table 3

CLINICAL RESULTS OF PREFRONTAL LOBOTOMY IN 107 PATIENTS

STATUS	NO. OF PATIENTS	PERCENTAGE OF TOTAL
Much improved	32	29.9%
Improved	30	28.0%
Slightly improved	24	22.4%
Unimproved	15	14.0%
Deceased	5	4.7%
Unable to evaluate because of physical complication	1	0.9%

It is apparent that 58 per cent of the group exhibited sufficient change in their clinical status to be regarded as improved or much improved.

Possibly a more tangible criterion of clinical improvement in the group is the number of patients who have been able to leave the hospital. At the present writing, 32 patients (30 per cent) have been released on indefinite trial visit. Of these, 25 are regarded as much improved, 6 as improved and 1 as slightly improved. In addition, several others are ready for indefinite visit and are merely awaiting appropriate housing or other necessary family adjustments. It is anticipated that at least 35 per cent of this series of 107 patients will be able to leave the hospital ultimately. In view of the chronicity of illness and the extremely unfavorable prognosis previously assigned to these individuals, this figure is indeed gratifying. Entirely aside from the humanitarian aspects, the financial saving which this represents to the state and to individual families is by no means inconsiderable, particularly in view of the long-term hospitalization which these patients would have required otherwise.

The hazards of the operation are not to be ignored; yet they seem relatively inconsiderable in view of the possible benefits which may be derived in the treatment of such malignant mental conditions. As noted above, there have been 5 deaths in our group of 107 patients. Of these, 4 deaths are regarded as attributable to the operation although one occurred in the immediate postoperative period. Accordingly, this represents an operative mortality of 3.7 per cent. However, it is pertinent to note that all but one of the deaths occurred among the first eleven cases and that there was only one fatality in the following 96 cases. In general, it can be stated that the operative mortality in a large series of cases will not exceed 2 to 3 per cent. Postoperative bleeding and infection appear to be the usual factors leading to fatality.

The most frequent complication has been the appearance of convulsive seizures. Ten of our patients have experienced post-lobotomy seizures—an incidence of 9.3 per cent. This figure may increase somewhat as further time elapses, inasmuch as the convulsions may not make their initial appearance until 6 to 12 months postoperatively. In general, it may be expected that at least 10 per cent of post-lobotomy patients will experience convulsive seizures. However, these represent slight hazard as in many cases only one or two convulsive episodes appear and in practically all instances they are readily controlled by the administration of anti-convulsive therapy.

There were several cases of mild meningitis which responded readily to appropriate therapy. Three patients required surgical exploration for complications: namely, one case of localized brain abscess and two cases of hemorrhagic cysts in the lobotomy tract. All responded well. Among the minor complications were two cases of edema of the feet or ankles, an unexplained complication whose occurrence has been described previously.[4] During the early phases of the program there were also two or three patients who appeared to experience hyperesthesia of the lower extremities. This feature disappeared after a few weeks.

In the great majority of cases the postoperative course was quite simple and uncomplicated. Most of our patients received intravenous pentothal anesthesia and they were restored to consciousness within a relatively short time. They were able to cooperate well with necessary nursing care despite the fact that many were extremely disturbed prior to lobotomy. Under ordinary conditions patients were permitted to be ambulatory within a week, a period which could have been safely shortened in many instances.

The clinical course of the post-lobotomy patient may be quite variable from the psychiatric standpoint. Prompt improvement in the immediate postoperative period does not necessarily indicate a satisfactory final result; conversely, and more fre-

quently, an apparently disappointing course during the early phases may be altered later in a favorable direction. In a significant number of cases a satisfactory result appeared only after some six months or more had elapsed.

Extended discussion of possible factors which may point toward success or failure with prefrontal lobotomy does not seem indicated in this preliminary report. Nevertheless a few comments in this direction may be pertinent. Undoubtedly, as Freeman and Watts[5] point out, the plane of incision in the frontal lobes is a most significant factor in obtaining a successful result. However, aside from any operative variants, there appear to be certain psychiatric components or symptoms which are particularly amenable to this form of treatment. Disturbed, overactive, aggressive individuals seem to derive optimal benefit. Patients with hostile, disturbing emotional drives, frequently in response to delusions or hallucinations, are helped by prefrontal lobotomy despite the observation that the delusions and hallucinations may persist. The theory that the behavior of these individuals is improved by the blunting of their emotional reactions to such disturbing psychic experiences seems acceptable. In our experience, apathetic, emotionally listless and deteriorated patients are rarely benefited. It is to be noted that the above symptoms have reference chiefly to the problem of chronic schizophrenia, which constitutes the major fraction of our patient group. In our experience, most cases of involutional psychosis and affective disorders can be treated satisfactorily with shock therapy, while obsessive states and other psychoneuroses which form a significant segment of the cases reported by Freeman and Watts, rarely seek admission to a state hospital.

A few comments concerning the effect of lobotomy on intelligence and initiative may not be amiss inasmuch as the opinion seems fairly widespread that post-lobotomy patients are reduced to the status of vegetative individuals. This viewpoint is contrary to our own experience and that of other investigators in the field. Although still in a preliminary stage, psychological testing* of our patients indicates that, although there may be a mild decrease in intellectual functioning during the ea postoperative phase, the intelligence is restored a level equal to or greater than the preoperat intellectual efficiency within six months after ope tion. Similarly, despite certain alterations in en tional attitudes, post-lobotomy patients are n divested of their interest and initiative. Instead, fre of their aggressiveness, hostility and nervous te sions, they are better able to apply themselves appropriate tasks and to resume occupational assig ments which were entirely beyond their scope pr to operation.

SUMMARY

Since May, 1946, 107 patients have undergone p frontal lobotomy at the Fairfield State Hospit The group was composed almost entirely of in viduals suffering from chronic mental illness wh prognosis seemed extremely unfavorable. T results following lobotomy were encouraging: per cent of the group were improved or mu improved; thus far, 30 per cent have been able leave the hospital on indefinite visit. The mortali was relatively low. Convulsive seizures represent the most frequent complication, occurring in a proximately 10 per cent of the group. Hosti aggressive, chronically disturbed patients appear derive the greatest benefit from this operati procedure.

*We are indebted to Mr. Joseph R. Grassi and his asso ates in the Psychology Department at the Fairfield St Hospital for the psychological examinations.

BIBLIOGRAPHY

1. Freeman, W. and Watts, J. W.: Prefrontal Lobotomy Agitated Depression. Report of Case. Med. Ann. Distr of Columbia 5:326-328, Nov., 1936.

2. Brody, E. B., and Moore, B. E.: Prefrontal Loboton review of recent literature. Connecticut M. J. 10:409-4 May, 1946.

3. Lyerly, J. G.: Transsection of the Deep Associati Fibers of the Prefrontal Lobes in Certain Mental Disorde South. Surgeon 8:426-434, Oct., 1939.

4. Ziegler, L. H. and Osgood, C. W.: Edema and Tropl Disturbances of Lower Extremities Complicating Prefron Lobotomy. Arch. Neurol. & Psychiat. 53:262-268, Ap 1945.

5. Freeman, W. and Watts. J. W.: Prefrontal Loboton Survey of 331 cases. Am. J. Med. Sc. 211:1-8, Jan., 1946.

ANTACID THERAPY FOR PEPTIC ULCER

The Use of a New Synthetic Resin

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It is only since the general use of the diagnostic x-ray that we have objective evidence of the presence of peptic ulcer in the living patient and that it can be accurately diagnosed. Although peptic ulcer did exist previously, generally speaking it is a disease of modern times. In 1935 the diagnosis of duodenal ulcer in some of our leading institutions was made by so called "secondary signs" and was often wrong. In the last ten years with the general adoption of aimed compression serial technique as developed by von Bergmann and Akerlund in the 1920's an objective diagnosis of duodenal ulcer is accurately made. There are still some diehards who are not convinced of the value of fluoroscopy combined with filming over the use of films alone. The improvement in the accuracy of determining the presence of ulcer and the general use by the profession of the x-ray for ulcer diagnosis, has resulted in the discovery of ulcer in a much larger percentage of the population than was thought suffered from ulcer in the early years of the century.

With the improvement in diagnosis we are better able to judge therapeutic results. The antacids which had been used for centuries for dyspepsia in general were found to be much more valuable in the treatment of ulcer than other diseases. As early as 1895 Von Strumpell used a mixture of bismuth subcarbonate and sodium bicarbonate to treat gastric ulcer, but it was Bertram Sippy of Chicago who in 1917 gave us the idea of continuous acid removal as necessary for the healing of the much more common duodenal ulcer. The best available antacids in Sippy's day were sodium bicarbonate, bismuth subcarbonate and magnesium oxide. He used the constipating bismuth salt to counteract the laxative effect of magnesium oxide. Sippy soon learned that bismuth salts were very poor antacids and in his last years discontinued their use and replaced them with calcium carbonate. Unfortunately standard Sippy powders still contain the valueless bismuth salt. Per unit of weight, magnesium oxide is still the most active antacid we have, but it is so laxative in action and after ingestion causes such a marked secondary acid rise that it has fallen into disuse.

In the past quarter of a century several other methods of ulcer therapy have been suggested. I will mention a few: diathermy, x-ray therapy, injections of foreign protein, emetine hydrochloride mixed with foreign protein, streptococcus vaccine, the amino acid histidine, amino acids, histamine hydrochloride and anterior pituitary snuff. None have proven of much value. Clinical experiments with urogastrone (Sandweiss) and enterogastrone (Ivy) are as yet inconclusive. However, many improvements have been made in the treatment of ulcer.

The regime used by Sippy has been modified to advantage. He used mixtures of milk and cream. Since many patients are cream sensitive the use of this mixture has given way to whole milk. Pureed vegetables and other foods are used at the onset of therapy instead of milk and cream alone. Sippy starved his bleeding patients. Andreson first pointed out that there was an advantage in promptly feeding bleeding ulcers though Meulingracht is given credit for this finding. The antacids used by Sippy had many disadvantages. Calcium carbonate was too constipating and magnesium oxide too laxative and to strike a happy medium in the dosage of each for an individual patient was almost impossible. The sodium bicarbonate used was absorbed and caused alkalosis. Both sodium bicarbonate and calcium carbonate when neutralized produced carbon dioxide which the patient belched to his embarrassment and often amusement of his friends and relatives. The introduction of the tribasic salts of calcium and magnesium and aluminum hydroxide and phosphate jels and of magnesium trisilicate were an im-

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provement on the antacids used by Sippy. Unfortunately these new antacids all have constipating or laxative action upon the bowel. In some patients fecal impactions have been caused by aluminum hydroxide jels. The discomfort caused by the irritating effect on the intestines is more difficult to manage than the pains caused by the ulcer. The search for an ideal antacid continues.

THE NATURE AND USES OF SYNTHETIC RESINS

In 1938 while seeking an improved antacid, I discussed acid adsorbents with Mr. Howard Tiger, a water purification engineer. He had recently returned from a trip abroad on which he had investigated the Adams and Holmes report on the ion exchange properties of certain synthetic plastic resins. We computed that of the resins then available in order to remove sufficient acid in a patient with ulcer about a pound a day would have to be ingested to promote healing.

Synthetic resins are plastic substances which have been developed in a great variety of chemical formulae since 1906 when Baekeland discovered the substance now called bakelite. These synthetics were called resins because they had a physical resemblance to such natural resins as amber; but there is no chemical relationships between synthetic and natural resins. These synthetic resins were highly prized for their hardness and inability to react with common chemicals and it was this inert quality which made them so useful for radio panels, hair brushes, and the like. It was known that some of these resins had biologic properties as they produced a dermatitis on the hands of sensitive users. Adams and Holmes in 1935 discovered that resins of a type known as phenol formaldehyde condensates could remove acids from solutions. If passed through an alkali medium the acids were released and the resin was restored to its original state of usefulness. Such a substance which lent itself to rejuvenation, immediately found extensive use in the water purification industry. Both acid and alkali adsorbing resins were produced.

During the war, resins of increasing acid adsorbing power were developed. Tiger had performed animal experimentation with the earlier anion exchange resins and proved their innocuous nature. Segal, working with one of the newer resins, showed them innocuous for rats and mice in doses so high as to constitute an equivalent of 20 per cent of the animal's diet over a period of many months. Martin improved on the acid adsorbing power of the resin used by Segal. This resin had sufficient acid r moving power to suggest it useful in the treatme of peptic ulcer in dosages of 10 to 15 grams over period of 24 hours.

Reports of its clinical efficacy have been pul lished by Spears and Pfieffer and myself. In th paper I will discuss my findings in one hundr patients with duodenal ulcer treated for from one seventeen months with resin.

The resin ion exchangers of which these phen formaldehyde condensation products are a grou have found wide usage in the chemical field ar present possibilities in therapy other than for trea ing peptic ulcer. Cation exchange resins should l developed to withhold sodium from absorptic through the bowel mucosa. Thus patients on lo sodium diets, cardiacs, nephritics, epileptics, and th like might be given a normal amount of salt in the diet provided they simultaneously ingested a specif amount of resin. I have discussed this possible use f resin with Mr. Tiger, but as yet no reports of anim experimentation have appeared. Until such a carried out no clinical studies can be made. Willia Dock has recently called attention to the possib oral ingestion of cation exchange resins to remov ingested sodium in cases of cardiac edema. Resi may be developed with the ability to adsorb irritatir exudates from wounds. A cation exchange resi placed about an iliostomy stoma or the opening of pancreatic fistula would adsorb the alkaline sma bowel secretions and prevent skin excoriation. Sinc resins act in any state no macerating solvent woul be required. The synthetic resins are also adsorbe of enzymes. Wilkinson and Martin have shown reduction of peptic activity to 17 per cent of i original value by the addition Amerlite IR IV to pepsin solution. While Segal's studies do not co roborate those of Martin, possibly the value of th resin as an antacid in treating peptic ulcer is e hanced by its simultaneous adsorption of pepsi This property of enzyme adsorption should mak resinous preparations all the more valuable in pr tecting the skin about duodenal and pancreatr fistulae.

The synthetic resins adsorb various alkaloids an slowly release them as the pH of a dissolvir medium changes. By combining a resin with a alkaloid one should be able to maintain a more eve adsorption of various alkaloids from the digestiv tract over a longer period of time than is now po sible. At present a patient usually complains of dr

ns and blurring of vision an hour after taking
atropine sulfate. This effect disappears before the
nt dose is given or during the night. Thus we
he an inconstant action. By combining a resin
wh an alkaloid we might produce a constant
physiologic effect over a 24 hour period. Other
obvious valuable combinations with alkaloids pre-
sent themselves.

EXPERIMENTS WITH A RESINOUS ANTACID

We were generously supplied with a resinous ant-
id by Dr. Gustav Martin of The National Drug
Company. This resin is a phenol formaldehye con-
densation product. It is called Amberlite IR IV in
crude state by the chemical trade and has been
given the pharmaceutic trade name Resinat. It
polymerizes freely and has a large molecule.

We added the resin to a fixed amount of N/20
HCl and also added it to specimens of gastric juice
obtained from patients. We compared the neutral-
izing power of the resin with calcium carbonate and
with an aluminum hydroxide suspension in common
use. On a volume basis we found that the neutral-
izing power of the resin was less than that of calcium
carbonate but better than for the aluminum hydrox-
ide suspension.

The resin we used was of the 200 mesh type pre-
pared by Dr. Martin. By further grinding, it is
hoped that a finer mesh resin can be produced. The
ideal resin should approach the neutralizing power
of calcium carbonate. The 200 mesh resin of Martin
has several times the neutralizing power of the lar-
ger mesh resin used by Segal. Further endeavor by
pharmacologists should produce a finer mesh resin
and further enhance the acid adsorbing power of
the material. Acid adsorption appears to be a sur-
face phenomenon. The finer the mesh of the resin
the greater surface exposed and the more acid
adsorbed.

USAGE AND METHOD OF ADMINISTRATION

I have used a set of three ulcer diets (Tables 1, 2,
and 3) for the past eleven years to evaluate various
antacids. These diet schedules are easier to use than
the standard Sippy regimes and provide a more
adequate intake and greater variety of food. Eighty
per cent of our patients have been started on the
Semi-Ambulant Ulcer Diet (abbreviated S-A) while
twenty per cent have been started on the Hospital
Diet. These diets avoid the use of continuous drips
of either milk or aluminum jels. Drips of various
types while efficacious render the treatment of ulcer
needlessly complex. In the hospital, night hyper-
secreters are awakened by the nurse and fed milk
and antacid where indicated on the schedules. The
patients treated at home set their alarm clocks a
half hour before the usual time of onset of their
night pain and drink some milk and take some ant-
acid. The diets are self explanatory and save the
physician needless calls from patients or hospital
attendants. Affixed to a hospital chart they save the
time required for writing orders. The antispasmodic
used on these diets is prescribed as follows:

℞ Atropine Sulphate .0003
Phenobarbital .015
Milk Sugar q.s.
D.T.D. capsules No. XXX
Sig: Antispasmodic: One capsule where directed
on diet schedule

The resin is used in doses of from .5 to 1 gram.
I have been using .75 grams as an average dose. Since
our resin is now prepared in .25 gram capsules we
label the bottle: "Antacid: 3 capsules when directed
on diet schedule." On the Semi-Ambulant regime
the patient will require 18 to 24 capsules per day.
These diet schedules can be used with any antacid.
I have used them with aluminum hydroxide suspen-
sions and with magnesium trisilicate as the antacid.

Complicated ulcers and those patients whose
symptoms do not subside in twenty-four to forty-
eight hours on the Semi-Ambulant regime are hos-
pitalized. In the hospital I prescribe .75 grams (3
capsules) of the resin during the day and 1 gram (4
capsules) at night wherever the antacid is indicated
on the Hospital Diet. If the patients have a partial
obstruction no feedings are given after 6 P. M. and
the stomach is emptied with the aid of a Wangen-
steen apparatus at 10 P. M. No night feedings are
given to these obstructed cases. If the 10 P. M.
residual does not diminish to less than 100 c.c. in
three days I consider such patients unsuitable for
medical treatment. All patients are kept on the
Semi-Ambulant Ulcer Diet for six weeks. Patients
hospitalized are usually released after two weeks
and are then also placed on the Semi-Ambulant
regime for six weeks. After six weeks of the Semi-
Ambulant regime all patients are placed on the Diet
for Quiescent Ulcer. Patients are advised that this
last sort of diet must be followed for many years and
in ulcers with much deformity or for those who
bleed frequently, for life. I think the adherence to
such a regime and the continued use of antacids and
antispasmodics is the crux of the prevention of ulcer
recurrence. In patients willing to abide by this

regime for many years, relapses rarely occur. To date the disagreeable side effects of antacids and the nuisance of carrying liquid suspensions of aluminum hydroxide have caused patients to discontinue their use as soon as symptoms subside. The resin we have been using has to date shown no such side actions. We have had patients taking several grams a day for 17 months with no ill effects. During the season of the year when an ulcer tends to relapse, we advise return to the Semi-Ambulant Diet for about six weeks.

CLINICAL RESULTS

1. *Hospitalized Patients:* We have treated 100 cases of x-ray proven duodenal ulcer and two cases of gastric ulcer with resin. Eighteen of these patients were hospitalized. Of the hospitalized patients six were *hospitalized* because of severe hemorrhage requiring transfusions of whole blood. All of these bleeding patients did very well. The one bleeding *gastric* ulcer was electively subjected to sub-total gastric resection because he had had repeated hemorrhages and the benignity of the ulcer could not be proven by x-ray nor gastroscopy. Four of the hospitalized patients having marked obstruction and one having a partially penetrating ulcer were given resin as an antacid while being prepared for surgery. Two other obstructed cases responded for some time to resin therapy but later also required sub-total gastric resection. The remainder of the hospitalized case (5) had complicated duodenal ulcers of many years duration. Nine of the ten non resected hospitalized cases have been free of symptoms for from three to seventeen months. Two recurrences have occurred in one patient at five and nine months. He is a watchman, works nights and was unable to follow an ulcer regime. He later required a sub-total resection.

2. *Ambulant Patients:* Of the 82 patients started on the Semi-Ambulant diet and later placed on the Diet for Quiescent Ulcer, 76 have been symptom free for from one to seventeen months. Three had recurrences after disregarding their diets but improved promptly on a return to a rigid regime. Two patients failed to remain symptom free either on resin or on other antacids. One patient who obtained no benefit from resin does well on an aluminum hydroxide suspension. Two patients had relapses on the Diet for Quiescent Ulcer but their symptoms cleared promptly on return to the Semi-Ambulant regime.

Eighty-five per cent of our patients have been kept symptom free on our ulcer regime using re as the only antacid.

None of our patients have had any side effe as a result of resin therapy. Particularly noticeal is the lack of complaints regarding constipation a diarrhea and the freedom from bloating and gas.

At present, the resin is dispensed in capsules. As generally known gelatine capsules themselves ca heartburn in some people. Technical difficult have to date prevented the manufacture of co pressed tablets. When this difficulty is overcome t resin should enter into combination with the gast acid more quickly and further improve our tre ment.

SUMMARY AND CONCLUSIONS

1. An antacid synthetic resin has been describe

2. Its usefulness in treating peptic ulcer is d cussed.

3. Diet and medication schedules for treatment peptic ulcer are presented.

4. Synthetic antacid resins do not have any u toward effect on the digestive tract. They cau neither constipation nor diarrhea. Since they are n absorbed, they do not alter the acid base balance the body. Since they can be cheaply produced th should replace the antacids now in use.

TABLE 1

SEMI-AMBULANT ULCER DIET

Diet for M.....

During the period of this diet, which should last about weeks, the patient should rest as much as possible. Rel avoid arguments, and do not see too many visitors. Follo the schedule explicitly. *If you must work* go to bed for yo evening meal and stay there. Spend your time off (Sunda etc.) at rest. Choose from the allowed foods. Eat sm meals.

SCHEDULE

7:55 A. M. *Antispasmodic*

8:00 A. M. 1 plate of cooked, mashed prunes, passed throu a collander.

½ cup of cooked cereal, (Cream of Whe Farina, hominy, Pablum or oatmeal).

1 soft boiled egg, 1 slice of toast and butter, mi or Kaffee Hag, or Sanka with cream.

9:00 A. M. Antacid.

10:00 A. M. Glass of milk.

11:00 A. M. Antacid.

11:55 A. M. *Antispasmodic*

12:00 M. Any milk or creamed soup unseasoned ar strained. Cream cheese sandwich. White bre and butter.

Puree of peas, lima beans, carrots, asparagus tips, beets, squash, spinach or cauliflower. ½ cup of steamed or boiled rice, macaroni, spaghetti, or noodles, with butter. Small serving of mashed potatoes with butter. 1 slice of toast and butter. Gelatin preparations or rice, tapioca, bread or custard puddings without raisins or nuts; or stewed fruits if passed through a collander, and without syrup.

00 P. M. Antacid.
30 P. M. Glass of milk.
30 P. M. Antacid.
30 P. M. Glass of milk.
55 P. M. *Antispasmodic*
00 P. M. One soft boiled egg, or plain omelet, or cottage cheese with sweet cream. Pureed vegetable as at luncheon.
Small baked potato without skin but with butter. Desserts as at luncheon. Toast and butter.
:00 P. M. Antacid.
:30 P. M. Glass of milk.
:30 P. M. Antacid.
:25 P. M. *Antispasmodic*
:30 P. M. Glass of milk and antacid.
Set alarm for following hours:

Do not use seasoning for any of these foods. A pinch of t may be used. Milk may be malted.

You may drink tap water without ice as you wish.

If any questions arise, phone the doctor.

Table 2

)SPITAL DIET AND DIRECTIONS FOR COMPLICATED PEPTIC ULCER

Standing Orders for Nurses

This diet is prescribed for patients who are suffering from ute hemorrhage, from partial pyloric obstruction, gastric cer and penetrating duodenal ulcers. For the first three ys the patient must be kept in bed except to use the toilet. bleeding cases a bedpan must be used. Visitors restricted. *eedings and medication must be given exactly at time dered.*

7:55 A. M. Atropine Sulphate .0003 gms. Phenobarbital .015 gms.
8:00 A. M. Cooked cereal oz. 4, sugar dram 1, cream oz. 1, milk oz. 8.
9:00 A. M. Antacid.
0:00 A. M. Milk oz. 8.
1:00 A. M. Antacid.
1:55 A. M. Atropine Sulphate .0003 gms. Phenobarbital .015 gm.
2:00 M. Pureed vegetables oz. 4 with butter, mashed potato oz. 4 with butter. Cup custard.
1:00 P. M. Antacid.
2:00 P. M. Milk oz. 8.
3:00 P. M. Antacid.
4:00 P. M. Milk oz. 8.
4:55 P. M. Atropine Sulphate .0003 gms. Phenobarbital .015 gm.
5:00 P. M. Pureed vegetables oz. 4 with butter, mashed potato oz. 4 with butter. Jello and cream 1 oz.
6:00 P. M. Antacid.
7:00 P. M. Milk oz. 8.
8:30 P. M. Antacid.
10:00 P. M. Milk oz. 8, antacid; Atropine Sulphate .0003 gm. Phenobarbital .09 gm.
12:00 Milk oz. 8 and antacid.
3:00 A. M. Milk oz. 8 and antacid.
6:00 A. M. Milk oz. 8 and antacid.

Ascorbic Acid Tablet 100 mgm. b. i. d. by mouth. Parenteral B. Complex (Lederle) 1 c.c. i.m. daily. After four days of this diet if the patient is symptom free add to diet as follows:

8:00 A. M. Pureed prunes oz. 4, slice toast, butter, soft boiled egg.
12:00 M. Milk Soup oz. 4, slice toast and butter.

If the patient has no night pain the feedings after 10:00 P. M. may be discontinued after the third day.

Table 3

DIET FOR QUIESCENT ULCERS AND ALLIED DISORDERS

Diet for M.....

In health, the gastric juice is acid. When this acid becomes too high, it may cause distress. Physicians call this increase in acid, gastric hyperacidity. It is commonly referred to as "sour stomach." Hyperacidity may be associated with gastritis or peptic ulcer or it may aggravate these conditions if they are present. Patients who have an ulcer should, in order to prevent recurrence, follow this diet which keeps the gastric acid at a low level.

In addition to carefully adhering to the diet, you must eat slowly and at regular times and chew your food thoroughly. It is best to relax on a sofa for a half hour before and after meals. You must avoid strain, worry, and arguments, especially at meal time and you must get at least 9 hours of sleep each night. Eat your main meal at noon, spend your holidays and weekends in quiet and relaxation. Don't try to fight your illness; give in to it. *Eat very small meals,* leave the table a bit unsatisfied. Take food between meals and at bed time to appease your appetite. If some of the allowed foods disagree with you, avoid them and substitute others on the list Take your anitspasmodic 15 minutes before meals and at bedtime and your antacid 20 minutes after meals and at bedtime if prescribed.

FOODS TO BE AVOIDED

Salty, sour, spicy, sharp, uncooked and rough foods. Salted and smoked fish and meat. Sausages, balogna and salami. Corned meats. Shell-fish. Canned fish and meats, as salmon, sardines, and deviled ham. Bacon. Ham. Hors d'oeuvres. Oily fish as salmon, herring, mackerel, or shad, meat soups. Broths. Bouillon.

Raw and dried fruits and vegetables except as mentioned in schedule. All salads, dressings and gravies. Coarse vegetables like cabbage, onion, celery, radish, cucumber and lettuce.

All condiments as pepper, mustard, vinegar, ketchup, horse radish, pickles, olives, chowchow, Worcestershire sauce.

Sharp cheeses. All nuts. Bread and cereals made from bran

and whole wheat. Stale bread. Poppy seeds, caraway seeds. Very hot or very cold foods taken on an empty stomach as very hot soup, or ice cream. Soft drinks as gingerale, Coca Cola, and cream soda. Coffee. Strong tea. *No smoking. No alcoholic beverages in any form.*

SCHEDULE (CHOOSE FROM FOLLOWING)

Antispasmodic. BREAKFAST.

Strained juice of one-half orange. Apple sauce. Stewed fruits, as prunes, apricots, and pears, baked apple without skin. Cooked cereals with cream or milk, and sugar. Soft boiled or poached egg. Toast, roll, or white bread and butter. Cocoa, Sanka, Kaffee Hag, or milk.

Antacid.

10:30 A. M. *Malted milk, fresh buttermilk, milk, weak tea with sugar and cream, graham crackers, Uneeda biscuits, or other plain crackers.*

Antispasmodic. MAIN MEAL (preferably at noon).

Creamed soup, (potato, tomato, spinach, asparagus, pea, corn, bean, celery, carrot) strained. Chicken or lean tender beef boiled, broiled or roasted. Do not eat the spiced outside cuts. Squab, turkey, Guinea hen, sweetbread, broiled liver. *Eat only tiny portions of any of these meats.* Boiled or broiled white fish, bass, blue fish, sole, carp, pike, or trout. Restrict meats to only once a week and it is better to favor fish and the lighter meats like chicken.

Thoroughly done pureed vegetables. Occasionally tender lettuce leaves without dressing. Boiled, mashed or baked potato. Gelatine, custard or pudding for dessert. Occasionally stewed fruits with cream avoiding the syrup and skins. Occasionally plain sponge or angel cake.

Antacid.

4:00 P. M. *Malted milk, fresh buttermilk, milk, weak [illegible] with sugar and cream, graham crackers, Uneeda biscuits [illegible] other plain crackers.*

Antispasmodic. SUPPER OR LUNCH.

Fresh boiled or broiled fish, (only fish with white flesh [illegible] oysters. Boiled or poached eggs. Cream cheese, Swiss che[illegible] pot cheese and sweet cream. Boiled rice or noodles or m[illegible] roni or spaghetti with butter and sugar only. Mashed, boi[illegible] or baked potatoes. Bread and butter, toast or rolls. Gel[illegible] dessert or pudding or occasionally plain sponge or a[illegible] cake or small portion of vanilla ice cream or stewed f[illegible] avoiding sweet syrup. If you carry lunch take a cheese, [illegible] or chicken sandwich.

Antacid.

10:00 P. M. *Malted milk, fresh buttermilk, milk, weak [illegible] with sugar and cream, graham crackers, Uneeda biscuits, [illegible] other plain crackers.*

Antispasmodic and antacid.

Drink water as you wish. You may drink any plain car[illegible]nated water as White Rock, Vichy, Poland Water, Ka[illegible], Seltzer, and Saratoga Water. A small glass of diluted orar[illegible], tomato (plain) or grapefruit juice must be taken daily w[illegible] a meal.

Many patients are sensitive to and made ill by milk. [illegible] this is true in your case take the tea and crackers betw[illegible] meals.

If any questions arise call the doctor.

A MODERN CONCEPT OF RESPIRATION AFTER R. F. PITTS

IRVIN G. SHAFFER, M.D., *New Haven*

IN THE past hundred years there has accumulated a rather impressive mass of evidence which tends to indicate that the indispensible mechanism for neural control of respiration is located in the reticular formation of the medulla.

In 1880 Markwald and Kronecker[1] divided the respiratory center into the inspiratory and expiratory portions. In 1923 Lumsden[2] distinguished four centers, a pneumotaxic, apneustic and expiratory as well as a gasping center. As late as 1929 Henderson and Sweet[3] maintained that only one respiratory center existed. Because of the indefinite localization of the medullary respiratory center, and the disagreement concerning its functional subdivision, Pitts, Magoun, and Ranson[4] set about stimulati[illegible] the respiratory center with the Horsley-Cla[illegible] stereotaxic instrument. Their investigations we[illegible] carried out on cats, anesthetized for the most pa[illegible] with 15-25 mgms. of nembutal per kilo of bo[illegible] weight injected intravenously, and supplement[illegible] with ether during operative procedures. Bi-pol[illegible] electrodes of enameled nichrome wire were us[illegible] for stimulation, the tips being separated about [illegible] mm. along the axis of the electrode. Subsequentl[illegible] all the points stimulated were identified by We[illegible] stained serial sections, cut in the plane of the pun[illegible] tures. Respirations were recording by attaching [illegible] small spirometer in the form of a Krogh bas[illegible]

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tabolism machine to a tracheal canula. Carbon dioxide was absorbed by a soda-lime tube placed nt to the canula to minimize dead space. This set-u records respirations and is independent of body nvements. For routine examination, a stimulus ensity of 8 volts and 240 stimuli per second was d. With this stimulus there was no spread of ction beyond the points of the electrodes.

On medullary stimulation these investigators ed two striking types of response; the one was a eep inspiration, tonically maintained throughout t duration of the stimulus, and the other an ex-pation likewise tonically maintained. In both types o response apnea was maintained uninterrupted b any rhythmic respiration for the duration of the s nulus. These responses, inspiratory apnea and intained expiratory apnea, it was found, could be ained only from definitely localized regions. A t rough exploratory stimulation of the pons, dulla, and upper cervical cord were then carried c to accurately delimit the extent of these regions. A proof that the current used caused little spread b yond the tips of the electrodes, it was possible in c tain regions to obtain a complete reversal of r ponse from expiration to inspiration on moving t electrodes 1 mm.

If you will look at the chart, you will see at a g nce the area which has been localized as the r piratory center. You will notice that it is com-p sed of an expiratory and an inspiratory center, t inspiratory neurones being designated by the h vy triangles and the expiratory neurones by the c ts. If you will look at the cross section on the u per right hand side of the chart which was taken t ough the point marked "10", you will see that t inspiratory neurones lie ventral to the expira-t y neurones. If we were to put this localization i o precise terminology, we should say that the r ximal inspiratory and expiratory responses were o tained from the reticular formation of the medulla i the region of the inferior olive. The expiratory r gion lies dorsal to, slightly cephalic to, and cupped o er the cephalic end of the inspiratory region w ich itself rests as a plate over the dorsal surface o the upper four-fifths of the inferior olive.

I know that when I was in medical school I was t d that the respiratory center was roughly in this r gion of the medulla; but I conceived of it as o cupying the volume of a match head. It has now b en shown that in the cat the inspiratory and e piratory regions each occupies about 30 cu. mm. o the reticular formation.

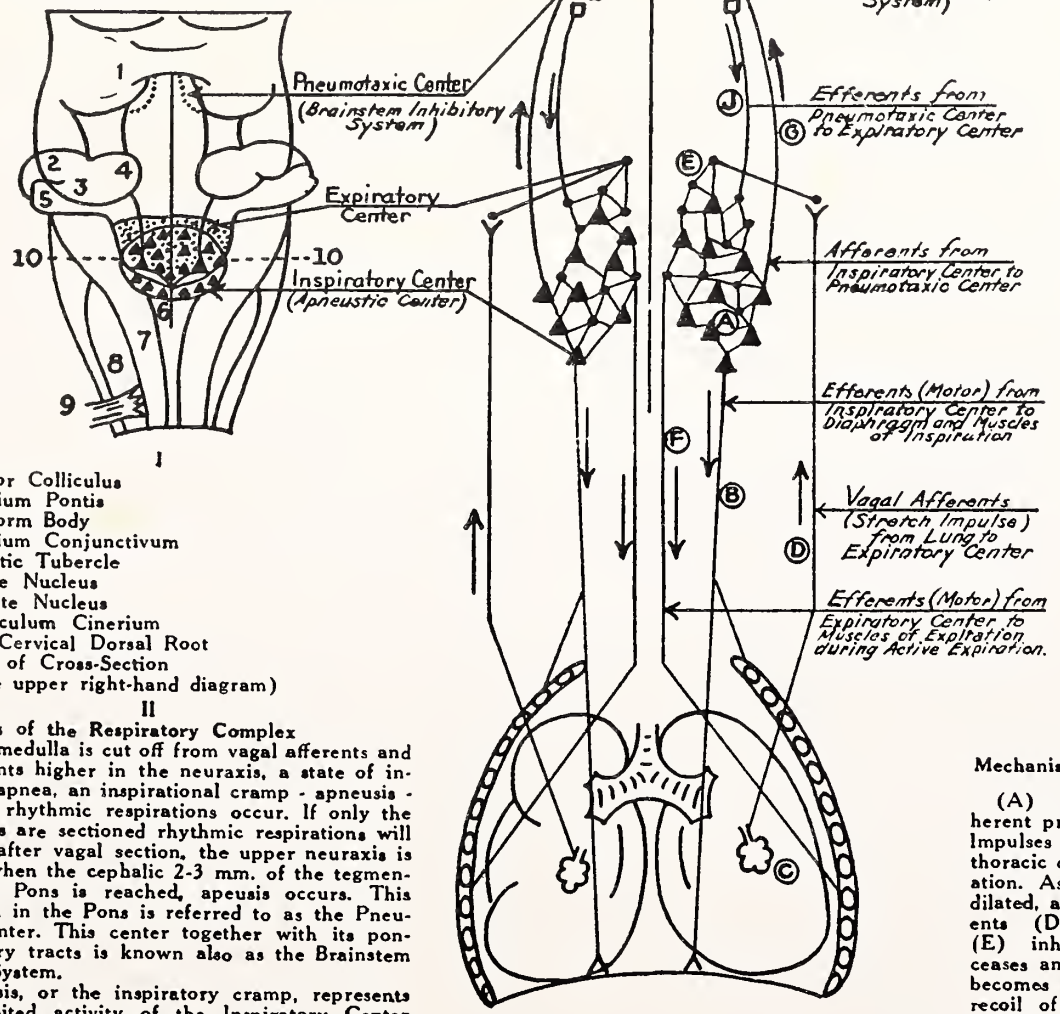
After having localized the respiratory center Pitts, Magoun and Ranson[5,6] then thoroughly explored the brain stem from a level in front of the hypothalamus to the cervical cord, and obtained these maximal responses from no other region. Since stimulation of one point will cause a maximal response ofttimes, rich interconnections, synaptically, join the respiratory neurones.

In 1880 Markwald and Kronecker used the term "Inspiratory Cramp" to denote inspirational apnea. The term "Apneustic Respiration" was coined by Lumsden in 1923 and he took it to mean a state of inspirational apnea maintained for seconds, interrupted by a few gasps, only to appear again. Lumsden ascribed this apneusis to the liberation of the medullary apneustic center from the rhythmic drive of a higher pneumotaxic center, located in the uppermost pontile level. However, he had failed to note the important contribution which the vagus makes toward rhythmic respiration. This vagal effect had been pointed out by Markwald in 1887,[7] Henderson and Sweet in 1929 and most recently by Stella in 1938.[8] These men confirmed Markwald's findings that apneustic respiration was produced when the vagi were cut as well as the brain stem. The next link in the chain of events was the problem of the accurate localization of a pontile center and evaluation of its function. This, too, was done by Pitts and his co-workers, and the brain stem pneumotaxic or inhibitory center was localized to the tegmentum of the upper few mm. of the pons as shown here on the chart. Some previous workers in the field had put it at the level of the inferior colliculus and others at the level of the red nucleus. In addition, the pathways connecting the pneumotaxic center and the medullary respiratory center were identified and found to be located ventrally and far laterally in the pons and upper medulla. These tracts are ventral and slightly medial to the descending root of the trigeminal nerve.[9]

Let's turn then, to the components of the respiratory complex. We have found that if the medulla is cut off from the vagal afferents and from efferents higher in the neuraxis a state of inspirational apnea, an inspirational cramp, results; no rhythmic respirations occur. If only the vagal nerves are sectioned, rhythmic respirations will persist at a slower rate. Most of us have seen this demonstrated in the physiology laboratory. If, however, after vagal section the upper neuraxis is sectioned, when the cephalic 2 to 3 mm. of the tegmentum of the pons is reached inspirational apnea, an inspiratory cramp

A MODERN CONCEPT OF RESPIRATION - after R. F. Pitts

THE LOCATION OF THE INSPIRATORY, EXPIRATORY, AND PNEUMOTAXIC CENTERS



I

1. Inferior Colliculus
2. Brachium Pontis
3. Restiform Body
4. Brachium Conjunctivum
5. Acoustic Tubercle
6. Gracile Nucleus
7. Cuneate Nucleus
8. Tuberculum Cinerium
9. First Cervical Dorsal Root
10. Level of Cross-Section
(See upper right-hand diagram)

II

Components of the Respiratory Complex

If the medulla is cut off from vagal afferents and from efferents higher in the neuraxis, a state of inspirational apnea, an inspirational cramp - apneusis - results. No rhythmic respirations occur. If only the vagal nerves are sectioned rhythmic respirations will persist. If, after vagal section, the upper neuraxis is sectioned, when the cephalic 2-3 mm. of the tegmentum of the Pons is reached, apeusis occurs. This critical area in the Pons is referred to as the Pneumotaxic Center. This center together with its pontile-medullary tracts is known also as the Brainstem Inhibitory System.

Apneusis, or the inspiratory cramp, represents the uninhibited activity of the Inspiratory Center of the Medulla. This maintained inspiratory activity may be due to circular impulses within the Inspiratory Center or may represent a discharge of impulses over its motor neuron system because of chemical stimulation of CO_2 increase.

Normally, rhythmic respirations are maintained by the action of the Brainstem Inhibitory System and the Vagal Inhibitory System on the Inspiratory Motor Neurone System. Changes in CO_2 alter the susceptibility of the Inspiratory Center to inhibitory impulses, and alter depth of respirations, largely. O_2 want in-

A CROSS-SECTION THROUGH THE MEDULLA



III

1. Spinal Vestibular Tract
2. Restiform Body
3. Lateral Cuneate Nucleus
4. Spinal Tract of Trigeminal Nerve
5. Tractus Solitarius
6. Motor Nucleus of Vagus
7. Hypoglossal Nucleus
8. Medial Longitudinal Fasciculus
9. Medial Lemniscus
10. Inferior Olive
11. Corticospinal Tract
12. Expiratory Neurons
13. Inspiratory Neurons

IV

Mechanism of Respiration

(A) Inspiratory impulse from the center (the inherent property of the center) initiates inspirations. Impulses pass via efferents (B) in the cervical and thoracic cord to the diaphragm and muscles of inspiration. As the terminal bronchioles and alveoli are dilated, a stretch impulse is sent out via vagal afferents (D) to the Expiratory Center (E). From (E) inhibitory impulses pass to (A), inspiration ceases and expiration occurs passively. If expiration becomes active, as with obstruction, loss of elastic recoil of the lung, or exercise, impulses pass via efferents (F) in the thoracic cord to the muscles of expiration. These efferents from the respiratory center pass in the anterior and antero-lateral columns of the cord.

Impulses from (A) are carried to (E) and inhibit expiration. Impulses from (A) also pass via tracts (G) in the ventro lateral aspect of the medulla and pons, to the pneumotaxic or Brainstem Inhibitory Center (H). Efferent impulses from (H) travel back through the pontile-medullary tracts (J) to (E) and like the vagal inhibi-

inspiration and initiates ea[illegible]

occurs. The term "Pneumotaxic Center" has given the false impression to some of a compact aggregate of neurons, anatomically and functionally homogeneous, all of which must be eliminated in order to produce inspiratory cramp. More in line with experimental fact, is the view that there are a number of reflex connections at various levels within the upper and middle brain stem, the elimination of which leads to inspiratory cramp. It is for this reason that these workers in their later writings reverted to the term "Brainstem Inhibitory Mechanisms." The inspiratory cramp represents the uninhibited activity of the respiratory center of the medulla. This maintained inspiratory activity may be due to circular impulses within the inspiratory center similar, perhaps, to the circus movement described in auricular fibrillation. Or, it may represent a discharge of impulses over its motor neurone system because of the chemical stimulation of CO_2 increase. Stella, in his experiments, showed that if he hyperventilated an animal with a pontile section and then cold-blocked the vagi, he got a lower level of inspiratory cramp than he obtained in an animal that was not hyperventilated. If he allowed an animal to develop a hyperpnoea by rebreathing CO_2 and then cold-blocked the vagi he got a much higher level of inspiratory cramp; that is, the chest became fixed in a position of more nearly maximal inspiration. Normally, then, rhythmic respirations are maintained by the action of the brainstem inhibitory system and the vagal inhibitory system on the inspiratory motor neurone system or mechanisms. Changes in CO_2 alter the susceptibility of the inspiratory center to inhibitory impulses and affect depth of respiration, largely. By analogy we can say that if a man is given a large dose of strychnine so that he is on the verge of convulsions, it will take a larger dose of a barbiturate to sedate him than it would take to sedate a similar individual who had not received strychnine; that is, the center excited by CO_2 will require a greater stretch impulse carried by way of the vagi to inhibit that inspiration. Oxygen want largely influences rate of respiration by way of reflexes from the carotid (and aortic) body.

Now, let's turn to the chart again and follow normal respiration from beginning to end. Though our newer data robs the medulla of the property of rhythmic respirations, it still leaves it the property of inspiration. Assuming this one spontaneous inspiration, then, we can say that the inspiratory impulse (A) from the center passes by way of efferents (B) which lie in the cervical and thoracic cord, to the diaphragm and muscles of inspiration. As the respiratory bronchioles and alveoli are dilated, a stretch impulse is sent up via vagal afferents (D) to the expiratory center (E). This stretch impulse is our old friend the Hering-Breuer reflex. Pitts conceives of this impulse as being transmitted to the expiratory center because strong central stimulation of the vagus will give us an effect similar to direct stimulation of expiratory neurons: namely, inhibition of inspiration and subsequent expiration. From (E) inhibitory impulses pass to (A), inspiration ceases, and expiration occurs passively. If expiration becomes active, as with obstruction, loss of elastic recoil of the lung, or exercise, impulses pass by way of efferents (F), in the thoracic cord, to the muscles of expiration. These efferents from both the inspiratory and the expiratory groups of neurones, pass in the anterior and antero-lateral columns of the cord to synapse with the lower motor neurones of the cervical and thoracic cord. The expiratory act becomes active, it seems, when the stimulation to the expiratory neurones is increased.

Let us examine the influence of the brainstem inhibitory mechanism and see how it enters the picture. When inspiration begins, at the same time that impulses pass down the cord by way of (B) to the muscles of inspiration impulses are carried by way of tracts (G) in the ventro-lateral aspect of the medulla and pons to the brainstem inhibitory system. Subsequently, efferent impulses from (H) travel back by the pontile medullary tracts (J) to (E) and, like the vagal inhibitory mechanism, this brainstem inhibitory mechanism inhibits inspiration and initiates expiration. This means that rhythmic respirations will persist as long as one vagus or pontile medullary tract is intact.

In summary it can be said that this newer concept differs from the older ideas in that it definitely conceives of both inspiratory and expiratory groups of neurones. It represents the brainstem inhibitory mechanism as functioning in a manner similar to the vagal inhibitory mechanism. Rhythmic respirations depend upon the inhibitory impulses from either of these two systems acting upon the inspiratory motor neurone system. The medulla itself, if severed from the vagi and from efferents higher in the neuraxis, is capable of producing only an inspiratory cramp.

BIBLIOGRAPHY

1. Markwald, M., and Kronecker, H.: Arch. f. Anat. u. Physiol., p. 441, 1880.
2. Lumsden, T.: J. Physiol. 57:153, 1923; J. Physiol. 57:354, 1923; J. Physiol. 58:81, 1923; J. Physiol. 58:111, 1923.
3. Henderson, V. E., and Sweet, T. A.: Amer. J. Physiol. 91:94, 1929.
4. Pitts, R. F., Magoun, H. W., Ranson, S. W.: Amer. J. Physiol. 126:673, 1939.
5. Pitts, R. F., Magoun, H. W., Ranson, S. W.: Amer. Physiol. 126:689, 1939.
6. Pitts, R. F., Magoun, H. W., Ranson, S. W.: Amer. Physiol. 127:654, 1939.
7. Markwald, M.: Ztschr. f. Biol. 23:149, 1887.
8. Stella, G.: J. Physiol. 93:10, 1938; J. Physiol. 93:263, 19
9. Pitts, R. F.: J. Comp. Neurol. 72:605, 1940. Pitts, R I Amer. J. Physiol. 134:192, 1941. Pitts, R. F.: J. Neur physiol. 5:75, 1942. Pitts, R. F.: J. Neurophysiol. 5:403, 19 Pitts, R. F.: J. Neurophysiol. 6:439, 1943.

DOUBLE GALL BLADDER DEMONSTRATED BY ORAL CHOLECYSTOGRAPH

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The roentgen incidence of double gall bladder is comparatively rare.[3,4,5,7] During the past twenty-six years only nine cases have been reported in American literature, and two in the British literature.[3] Prior to Climan's[2] case in 1929, not a single case was reported as a result of roentgen ray examination. Climan reported the first known instance of a double gall bladder demonstrated by cholecystography. In Nichol's[9] and Sherren's[10] reported cases, their roentgen diagnoses were made by visualizing distinct calculi within the organ. Slaughter[11] and Trout reported a case of duplication of the gall bladder, but in neither of these latter cases was the gall bladder visualized by means of an opaque media. In view of the rarity of this entity, we feel the need for reporting an additional case.

The most extensive and exhaustive study on the subject of gall bladder anomalies was made by Boyden.[1] The anomaly in this case falls in the category of supernumerary vesicles.

According to Aschoff, the cells of the gall bladder bud proliferate, thereby giving rise to a number of cavities, separated by a septa. The cavities eventually fuse into one large cavity. When these cavities fail to fuse, supernumerary gall bladders are formed.

Graham et al[6] did not encounter a single case of double gall bladder in their series of 1,218 cholecystograms.

From the clinical aspect, this case represents no special point of interest.

In this case, the patient was a forty-five year old white male who complained of vague upper gastro-intestinal symptoms. A combined oral cholecyst gram and gastro-intestinal series revealed sma intestinal hypermotilty and hyperperistalsis, a defi itely enlarged hepatic outline, and two distinct, we defined gall bladder shadows. (Figure 1.) Scout fil of the gall bladder area taken fifteen hours after th



Figure 1

Scout film of gall bladder area revealing two distinct gall bladders, following a double dose of priodax

al administration of a double dose of Priodax veals two well defined, distinct, separate gall adders lying along the lateral third of the inferior rgin of the liver. The gall bladders are markedly osed, lying at the level of the bodies of L3 and L4. ne larger gall bladder measures 7.5 cm. by 3 cm., hile the smaller gall bladder measures 5.5 cm. by 3 cm. The larger of the two gall bladders reveals normal concentration without evidence of opaque negative shadows, and the smaller of the two gall adders appears to be slightly hypotonic and less ncentrated. The periphery of the organs are arply outlined. Subsequent film taken one and one lf hours after a fat meal reveals almost complete ptying ability of the smaller of the two gall adders, while the larger of the two gall bladders veals approximately seventy per cent emptying ility of the organ. In the oblique views, the serialo- ams of the gall bladder and duodenal loops reveal vo sharply defined gall bladder structures. (Figure)

The author herewith reports the tenth case of uble gall bladder in American literature, demon- rated by oral cholecystography.

In this case there are two distinct gall bladder adows, clearly visible and sharply demarcated.

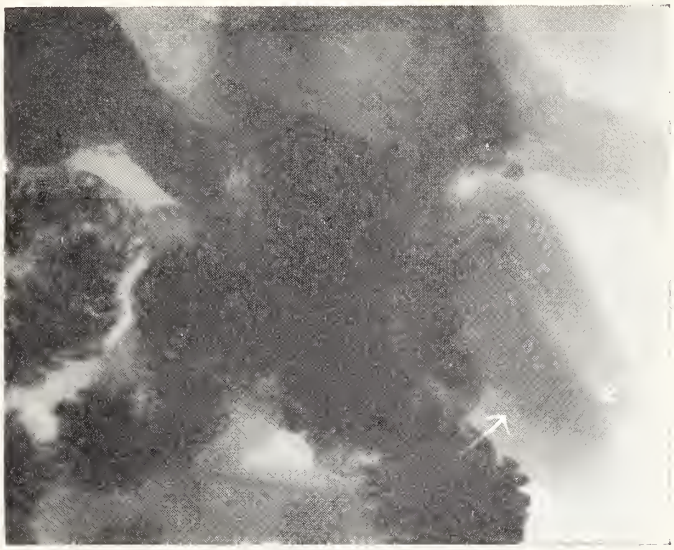


FIGURE 2

Serialogram of barium filled duodenal structures as well as the two distinct gall bladders

BIBLIOGRAPHY

Boyden, E. A.: The Accessory Gall Bladder. Am. Journal nat. 38:177, 1926.

Climan, M.: Duplication of the Gall Bladder demon- rated by Chlocystography. Med. Journal & Record 130: -74, July 17, 1929.

Cave, P.: Two Cases of Double Gall Bladder. Lancet. 751-752, April 4, 1931.

4. Feldman, M.: Clinical Roentgenology of the Digestive Tract. Baltimore. William & Wilkins, 1945.

5. Golob, M., & Kanto, J. L.: Two Cases of Double Gall Bladder. Am. J. Digest. Dis. 9:120-123. April 1942.

6. Graham, E. et al.: Diseases of the Gall Bladder and Bile Ducts. Phila. Lea & Febriger, 1928.

7. Haight, W. L.: Double Gall Bladder, cases. U. S. Naval Bull. 46:117-119, Jan. 1946.

8. Hayes, R.: Double Gall Bladder with Double Cystic Duct, Case Report, Radiol. 16:66-67, Jan. 1931.

9. Nichols, B. H.: Double Gall Bladder. Radiol. 6:255-256, Mar. 1926.

10. Sherren, S.: Double Gall Bladder Removed by Operation. Am. Surg. 54:204-205, Aug. 1911.

11. Slaughter, F. G. & Trout, H. H.: Duplication of the Gall Bladder, Case Report with Review of Literature. Am. S. Surg. 19:124-125, Jan. 1933.

PERIARTERITIS NODOSA — A CASE REPORT

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PERIARTERITIS nodosa was named by Kussmaul and Maier in 1866, though its lesions had been described by Rokitansky in 1852. Only 400 or so cases have been reported since then, and 80 per cent of these have been recognized only at necropsy. It occurs predominently in males, but no age is exempt, racial and geographic factors appear irrelevant, and similar lesions have been found in various animals.

The characteristic defect occurs in the wall of small and medium sized arteries; localized necrosis and infiltration, resulting in nodule formation, with thrombosis or aneurysm. Ischemia distal to the lesion accounts for the varied clinical findings. Lesions in different stages of development, including healing, with recanalization, are found in the same subject. No tissue is immune, but the most frequent sites, according to Gruber, are in order: kidney, heart, liver, stomach and intestines, etc., down to skin (13 per cent) and nervous system (10 per cent). The fatal outcome results either from excessive hemorrhage, or infarction of a vital point.

The etiology is still unknown. Case histories frequently include hemolytic streptococcic infections shortly before the onset, but this organism is not recovered from the lesions. Allergy is an even more common background finding, often of the single episode type. The *American Medical Association Journal* editorial of March 1, 1947 stressed a possible relationship to foreign protein reactions, and instanced the experimental production of typical periarteritis nodosa in rabbits through serum sensitization. Eosinophilia is often present in the blood and among the infiltrating cells about the vessels.

In brief, periarteritis nodosa is probably a local toxic or allergic response of the wall of small arteries to an unknown agent which temporarily disrupts the blood supply to a limited area, at many points in succession. Since the clinical signs are usually too confused for a diagnosis, and death results only after prolonged minor injuries, it is possible that many cases of this disease recover, without ever being identified. In the case reported below, these injuries continued four months, possibly for eighte months, and eventually reached a point incompatil with life.

PAST HISTORY

L. R., a clergyman, 62 years old, born in Cardiff, Wal had never been seriously ill before except for a "heart tack" in 1939. From the age of 15 to 20 he had worked a coal mine. He had had no allergic manifestations un 12 months before his final illness when he had had an atta of bronchial asthma. Its onset had been during the ragwe season and after the cold weather he had recovered.

PRESENT ILLNESS

In August 1946 a head cold was followed by a cough wi wheezing. Ephedrine was prescribed but the wheezi continued until October. During this time an acute asthmat attack was treated by adrenalin hyperdermically with reli Recurrent attacks of rhinitis followed and two months lat his right nares became obstructed. He consulted a nose a throat surgeon and several polyps were removed from h right nares. This procedure was followed by a persiste sero-sanguinous discharge from the right nares which co tinued until his death four months later.

Three days following the operation he became febrile a his temperature went as high as 101° F. Infection in h nasal passages and sinuses was suspected and penicillin spr was used without benefit. The surgeon who had remove the polyps examined him twice and found that normal hea ing had taken place but that the mucous membrane we extremely dry and crusted.

During this period at home his temperature was irregul but usually went to about 100° each day. He complained weakness, nausea, numbness of his fingers, stiffness of h neck and jaws, and profuse perspiration of his head an neck. He was admitted to the Day Kimball Hospital January 19, 1947, three weeks after the operation for nas polyps.

PHYSICAL EXAMINATION

He was of slight build and showed signs of great weigh loss. His muscles were poor in tone and he was so wea that he could not walk or feed himself without help. Th discharge from his right nostril was profuse and ser sanguinous. Because of the prominence of the nasal sympton during the entire illness, an excerpt from the examinatio by the nose and throat surgeon is given in detail.

"The right nostril is partly obstructed by an anteric deviation of the septum. There are no scabs nor pus. Th wall of the left nostril is weak. In the upper half of th

le nostril along the border of the inferior turbinate and thoughout the entire length of the back fissure, hard crusts a present, which are the color of dried blood. After they were removed a raw surface was observed, but no pus could be seen coming from the sinus openings. Transillumination showed both frontals and both antra quite clear. There is no tenderness over any sinuses."

His tongue was thickly coated and had a dry brown center. The blood pressure was 110 systolic and 90 diastolic. Other physical findings were normal.

Roentgenograms of the skull and sinuses were reported as showing some clouding of all sinuses on the left and there was considerable bone reaction about the left antrum and the left frontal. This was confusing as the polpys had been removed from the right side. In the films of the skull there were large areas of bone loss in the lower parietal and anterior occipital regions on the right and a smaller area of bone loss of the frontal and parietal bone on the left. A first osteomyelitis was suspected but Paget's disease was the final interpretation.

LABORATORY EXAMINATION

The white blood count was 15,000, with 46 per cent eosinophiles, 47 per cent neutrophiles and 7 per cent lymphocytes. The red blood count was 4,840,000 and the hemoglobin was 95 per cent. The urine was negative except for a lightest possible trace of albumen and the uncentrifuged sediment contained 3 or 4 r.b.c. per high powered field. A culture and smear from the nares was negative for diphtheria. The spinal fluid was normal in every way. Agglutination tests of the blood for typhoid, paratyphoid and Brucella infection were negative. The Mazzini test was negative. No parasites nor ova were found in his stools. Trichinosis was suspected because of the high eosinophilia, but muscle biopsy of a sore muscle in the forearm was negative for trichinae. Many eosinophiles were reported in the adjacent fat. A sternal puncture smear contained active bone marrow with eosinophilic hyperplasia but was otherwise normal.

Blood non protein nitrogen was 50.4 mgm. per cent, creatinine 4.2 mgm. per cent, uric acid 3.6 mgm. per cent, total serum protein 7.04 mgm. per cent. The sedimentation rate was 58 mm. in one hour. Renal function after phenolphthalein intravenously was 40 per cent in 2 hours. The blood sugar was normal. The hematocrit was 41. Blood alkaline phosphatase was 8.4 units per cent and the acid phosphatase was 2.5 units per cent.

Nodules in the skin were searched for daily but none were ever found so the diagnosis of periarteritis nodosa could not be confirmed during life. It was our diagnosis because the findings fitted nothing else.

Roentgenograms of his chest showed some fibrosis of the right upper lobe, a little emphysema and a little enlargement of the nodes in the left hilum. This latter was reported as slightly suggestive of Hodgkin's disease. Characteristic lesions of Paget's disease were found in the pelvis. An opaque enema was reported as revealing diverticulosis of the sigmoid. A gastro-intestinal series revealed a negative upper gastro-intestinal tract.

ELECTROCARDIOGRAM

Auricular rate 83; ventricular rate 83; sinus rythm. Intervals: P-R .22 sec. QRS .08 sec., QRST .33 sec. "Maximum amplitude of QRS is in lead II, and measures 9 mm. upward. Standardization: 1 mv. equals 1 cm. Position of patient: recumbent. Electrical axis: left axis shift.

"Depressed ST segments in leads I and II. T_1 is flat or diphasic, T_2 is flat or diphasic, T_3 is flat. In CF_4 and CF_5 the T wave shows deep late inversion. In CF_1 the main deflection of the ventricular complex is a deep downward wave. In the precordial leads, the R waves become increasingly tall.

"Electrocardiographic diagnosis: 1. First degree auriculoventricular block. 2. Left ventricle enlargement."

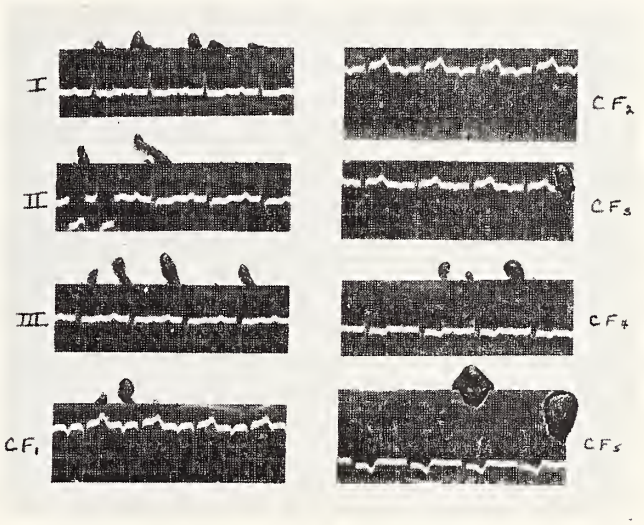


FIGURE 1

Electrocardiograph of a case of periarteritis nodosa

SUBSEQUENT COURSE

His temperature during the first six weeks of his stay was higher than it was during the last four weeks, but he ran a low grade febrile course throughout. The sero-sanguinous discharge from his nose was his chief complaint. Weakness became progressively worse and he was unable to feed himself. Pains in his extremities were bothersome at night. Profuse perspiration persisted. The sedimentation rate increased. The readings were 58 mm., 61 mm., 71 mm., 77 mm., in one hour. The non protein nitrogen rose to 155 mgm. per cent. After two transfusions it decreased to 80 mgm. per cent. The red blood count went as low as 2,500,000 and was improved only slightly after the transfusions. The white cell count went as high as 29,000, gradually decreased and four days before death was 11,000. The percentage of eosinophiles on admission was 46 per cent, went as high as 55 per cent and then gradually decreased until four days before death it was 10 per cent.

Wrist drop on the left developed twice and recovered in three days each time without treatment. Foot drop on the right occurred and remained. Neurological examination also revealed motor weakness of all four extremities and a

glove-stocking type of sensory diminution from the middle of the forearms and legs down. Vibration and position sense in fingers and feet were impaired to various degrees. The neurological picture was one of an infectious polyneuritis. He was able to be out of bed and to walk with help until three days before his death.

On March 31, 1947 the 71st hospital day, he suddenly became dyspneic and coughed up a large amount of blood. Respirations went to 50 per minute, temperature was 100 F. and his pulse rose to 120 per minute. He was placed in an oxygen tent with slight subjective improvement. Bubbling rales were present throughout the chest. Ten hours later he was conscious and rational but extremely pale and pulseless. His blood pressure was indefinite but was around 50 systolic. Three hours later he became unconscious and stopped breathing.

NECROPSY

(By Dr. Robert Tennant.) "The body is that of a well developed, but rather emaciated, white male. The skin and mucous membranes show extensive palor. There is no edema of extremities. The incisions are made as usual. No free fluid is present in any of the serous cavities.

"*Heart:* The heart in situ is somewhat enlarged. There are a few fibrous adhesions over the apex of the left ventricle. The heart weighs 470 gms. Beneath the area of adhesions there is an area of myocardial scarring, the result of an old, healed infarct. The coronary arteries show a marked sclerosis. The pulmonary, tricuspid, and mitral valves are normal. The aortic valve shows fusion of two cusps by a firm, red-brown vegetation approximately .5 cm. in diameter.

"*Lungs:* The lungs show marked anthracosis, each weighs 1000 gms. The surfaces are deep red and rubbery in consistency. A deep red fluid can be scraped from the cut surface.

"*Kidneys:* The kidneys together weigh 250 gms. They are pale and have a waxy appearance. The surfaces are smooth. On the cross section hemorrhage can be seen, particularly in the pyramidal calices. Some of these zones measure 3 mm. in diameter. The pelves are not dilated but also show zones of hemorrhage up to 5 mm. in diameter. The cortex of the kidney is reduced and averages 5 mm. in thickness.

"*Brain:* The brain is normal in appearance with minimal sclerosis of the basilar arteries.

"*Liver:* The liver weighs 1450 gms. The spleen weighs 110 gms. These organs show normal gross appearance. The gastro-intestinal tract, bladder, prostate, and adrenals are normal."

MICROSCOPIC EXAMINATION

"*Heart:* Sections of the heart show areas of focal fibrosis. One large area of scarring in the myocardium indicates old myocardial infarct. A few small vessels in the myocardium contain thrombi and there is a focal inflammatory infiltration adjacent to these vessels. The aortic valve shows a verrucous type of endocarditis. A mass of fibrin covers the valve edge and shows early organization at its point of attachment to the valve. The valve is thickened in this portion and a slight round cell infiltration is present.

"*Lungs:* The lungs show a hemorrhagic type of focal pneumonia. The alveolar spaces are filled with masses of red blood cells and also many polymorphonuclear le cytes. In a few zones the pneumonic process shows organization with masses of fibroblasts growing into alveolar spaces. The blood vessels in the lungs show unusual changes.

"*Gastro-intestinal tract:* Sections of the gastro-intes tract show intact mucosa. In the submucosa several s arteries are seen which show a perivascular collarin lymphocytes, plasma cells, and eosinophiles. A slight fib tissue proliferation is also present.

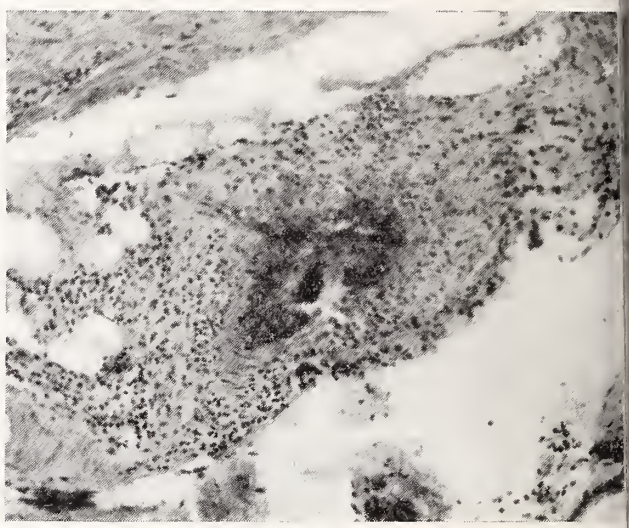


FIGURE 2
An artery from periprostatic area showing typical lesion of periarteritis nodosa



FIGURE 3
Periarteritis nodosa—heart showing verrucous endocarditis

"*Kidneys:* Sections of the kidney show marked chron nephritis which has the appearance of an embolic typ Glomeruli show portion of tufts necrotic and of amorpho pink appearance. Other glomeruli show older lesions wi hyalinization of part, or some times of the entire glome ulus. Glomerular adhesions are also present. Scarring

ma and atrophy of tubules is present in zones showing e marked glomerular involvement. The pyramidal por- of the kidney stroma shows focal areas of acute inflam- ory infiltration with hemorrhage associated with this tion. No arterial lesions are seen in the kidney sections.

Prostate: The prostate shows a benign overgrowth. In periprostatic tissue small arteries are seen showing typical ge of periarteritis nodosum. There is necrosis of vessel with thrombus attached to lining. A marked perivas- r infiltration with eosinophils, lymphocytes, and plasma is present and an early fibroblastic proliferation is also ent.

Liver: The liver shows a moderate degree of passive con- ion. The arteries are normal. Sections of the adrenals, reas, spleen show essentially normal structure.

ATOMICAL DIAGNOSIS

. Periarteritis nodosum with verucous endocarditis of ic valve.
. Cardiac hypertrophy-hypertensive type.
"Healed infarct of myocardium.
. Chronic nephritis (embolic) with uremia.
. Organizing and acute hemorrhagic pneumonia.
. Anthracosis."

IMARY

A case of periarteritis nodosa is reported. The nptoms were: asthma, sero-sanguinous nasal dis- rge, profuse perspiration, pain, parathesia and wasting of all four extremities and terminal hemoptysis. Prominent physical signs were: low grade fever, eosinophilia, wrist drop, foot drop, muscular atrophy, elevated sedimentation rate, elevated non protein nitrogen and terminal pulmonary hemorrhage. The diagnosis although made during life was confirmed only at necropsy.

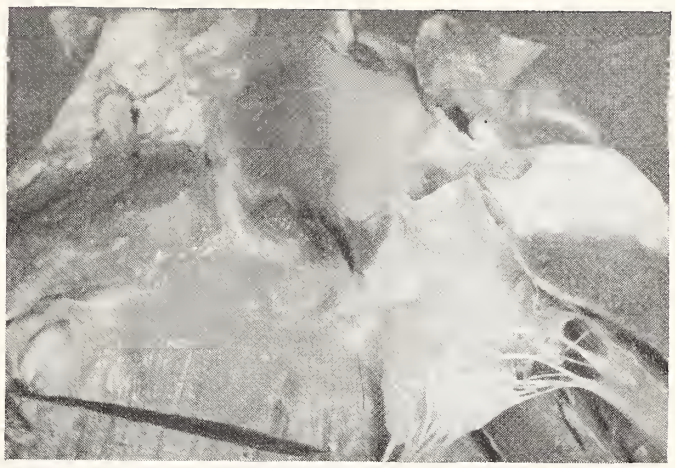


FIGURE 4
Heart showing aortic verrucous endocarditis

WELFARE MEDICAL CARE

WILLIAM H. HORTON, M.D., *Windsor*

The Author. *Medical Director, Office of the Commissioner of Welfare, State of Connecticut*

FOREWORD

The fee schedules for medical care of State Welfare partment beneficiaries are being revised at the present e. The revision is being undertaken jointly by representa- s of the State and of the Connecticut State Medical iety. This paper is presented with a view to clarifying existing State Welfare problem, to maintain and improve professional relations of the department by providing individual practitioner with the facts of the situation ich will aid in arriving at an equitable fee schedule.

THE activities of the State Welfare Department are the direct concern of every citizen of the te. These activities, being maintained by public nds, are the medium by which each individual citizen indirectly expresses his obligation to those less fortunate than himself. The fact that the individual taxpayer has no direct contact with the welfare beneficiary undoubtedly contributes to the great lack of public awareness of the scope and complexity of the welfare problem. Individual charities by which interested persons assist those of their acquaintance who are in need are admirable and in themselves provide a demonstration of the inherent interest which American people take in their fellowman. It is manifestly impossible, however, to rely on such interest by private individuals to care for the many persons who for one reason or another are in need of assistance. Thus, the State Welfare Department was established to initiate policies, maintain standards, and effect the payment of monies for assistance.

WELFARE AND THE DOCTOR

The doctor's responsibilities to the welfare program are both intellectual and professional.

Physicians are all graduate students and as such may be presumed to be included in the higher intellectual group of the community. Their experience and association with many individuals provides them with a background in human relations that is hardly possible in any other field. Intimate personal contact with patients must necessarily make them more aware of the anxiety which illness brings to otherwise well ordered families. Doctors as a group are community leaders, participating in the activities of Rotary and other service clubs in nearly every town. Many boards of education, school committees, libraries, and youth organizations find physicians among their members. Private welfare agencies have long been an especially strong field in which professional men have given their time, money, and influence. With this tremendous background of community service, it is idle to question the doctor's real interest in human welfare. It is also fair to assume that if he is informed about the activities of the State Welfare Department he will be as interested in those activities as he has shown himself to be in local civic affairs. The same responsibility for the profession exists in both cases.

The basic traditions of the medical profession require that medical care must be provided to all who need it. It follows that if the profession is to preserve its integrity, it must be willing to provide such care. Those who sit on the sidelines of medicine, the chiropractor, osteopath, faith healers, and others are watching with ever increasing interest the mounting struggle between organized medicine and the various governmental groups in their efforts to establish adequate medical care programs for those who are unable to pay. If the medical doctor is not willing to care for these less prosperous patients, there are a multitude of less qualified practitioners who are anxious to undertake the job.

There is no existing state-wide medical care program that is more efficient or less cumbersome than the present Connecticut welfare program for its beneficiaries. Other states may have more embracing, more expensive programs, but they all require more paper work, more red tape, and in many cases lower fees. If a sound medical care program for the indigent can be worked out within the State of Connecticut, we may set a pattern for other states and be of assistance in preserving state control of federally assisted medical care programs. t is toward this end that every physician should dir his efforts.

Welfare work will never end; it will show mir fluctuations with the economic situation in t country, but there will always be a steady incre in the number of beneficiaries in the old age gro as preventive medicine enables people to live lon and thus fall within the province of Old Age Assi ance. Latest statistics show that 99 persons p thousand 65 years and over living in Connecti are receiving Old Age Assistance. This figure pla Connecticut in a satisfactory position when it compared with the Massachusetts figure of 203 p thousand and the overall United States picture 214 per thousand. In the past ten years the perce age of the general population 65 years or over h increased. If this trend continues, and there is reason to suspect that it will not, a decade fr now we will find ourselves with a large segment our population in the old age group, non productiv and a considerable proportion, welfare dependen There will be no better time than the present strengthen our present satisfactory basic set-up, increase our service and to accept the responsibili which organized medicine bears toward the ben ficiaries of the welfare department. Since our pr fessional ethics and traditions obligate us to provi the care, it becomes solely a matter of what rei bursement will be made for the care and who w do the reimbursing. We are already on comm ground and we do not feel that the difficulties whi are current at present cannot be solved. They m be solved, for any alternative is very short-sight and will provide an invitation and open encourag ment to certain existing groups who are alrea bent on destroying the traditions of medical pra tice as we have known it.

Welfare Department

The State Welfare Department under its offici title, Office of Commissioner of Welfare, has thr main operating divisions, Child Welfare, Publ Assistance (which includes Old Age Assistance a Aid to Dependent Children) and State Aid a Collections.

CHILD WELFARE

The Division of Child Welfare has many respo sibilities, which include the care of neglected a uncared for children committed through the Juv nile Courts to the Commissioner of Welfare

ounty Boards of Management, the finding of ster homes, the licensing and supervision of all ivate child caring agencies and institutions and mes caring for children on a private boarding sis, social studies concerned with children for option, and home services for non committed ildren in their own homes. All of these services cept the last are maintained entirely by state nds, and professional medical expenses are paid rectly to the physicians. Beneficiaries at the oment are 1,730 children under six years of age mmitted to the Commissioner of Welfare and own as State Wards and 2,427 children from six eighteen years of age committed to the County mmissioners and known as County Wards.

BLIC ASSISTANCE

1. Old Age Assistance group consisting of about ,215 over the age of 65.

2. Aid to the Blind group consisting of 139 blind dividuals.

3. Aid to Dependent Children group consisting about 9,249 individuals which includes 6,580 ildren and 2,669 adults.

Monies which are furnished beneficiaries are from ate and federal sources. Under the provisions of e Social Security Board, a State may receive nancial assistance, termed "matching," which is dded to state appropriations for welfare care, roviding a certain method of payment to the neficiary is adhered to. *This is an exceedingly portant consideration.* First, because by accept- g federal assistance, the state is enabled to increase e scope and quality of its assistance program. cond, the Social Security law has been interpreted the Federal Social Security Board to mean that y assistance given must be in the form of a direct oney payment to the beneficiary, with which the *neficiary himself will contract and pay for his rious needs.* The monthly payment to beneficiaries r clothing, food, rent, and other recurring ex- nses is based upon established schedules within e department. Such unforeseeable and usually non curring items as medical care obviously cannot paid for in advance and therefore cannot be in- uded in the regular monthly check. When medical re is required, the beneficiary goes to a physician, ntist, or other professional man of his own choice r the necessary service. He is supposed to make s welfare status understood, and his services will billed at the rates agreed upon by the profes- sional man's State group. When the service is completed, the beneficiary receives his bill from the professional vendor, which he forwards to the State Welfare agency, who, finding it reasonable and proper, *issues a check to the beneficiary to cover this added expense.* In order for the State Welfare Department to receive the Federal matching, the check must be sent to the beneficiary without any instruction or advice as to its use or even a reference to the purpose for which the check was issued, the beneficiary being considered a self sufficient, responsible person able to handle his own affairs. This is the philosophy of the Social Security Board and the premise on which Federal aid for public assistance is given. It is then solely the responsibility of the beneficiary as to whether he does make payment to the professional vendor of the money which was given to him for that purpose by the Welfare Department. If he fails to do so, as numerous physicians and other professional people in the state have discovered, the State Welfare Department finds itself in an embarrassing position, not because it is obligated to pay the bills of its beneficiaries but because professional people, not being informed of this required payment procedure, feel that the State Welfare Department should be responsible. Also, there is no means by which the beneficiary may be compelled to meet the obligation, since both federal and state laws specifically exempt all welfare payments to beneficiaries from any assignment, attachment, garnishee, or other proceedings.

It will be apparent from the foregoing that the welfare department is in a dilemma. If we are to accept federal monies, we must accept the possibility that some of our beneficiaries will fail to complete their obligation of paying vendors, who in good faith have provided medical care according to the agreements between their respective societies and the welfare department, and so embarrass our good relations with those groups. On the other hand, if we are to make direct payment to the professional vendor, we must forego federal monies which are of great benefit to the Connecticut taxpayer, since it reduces the welfare costs. The Commissioner of Welfare acts in this situation to the best interest of all the state. He accepts the federal matching in the interests of operating a satisfactory, economical program, and he relies upon the understanding of the professional groups to provide medical care without prejudice until a more satisfactory arrangement can be made. It is our opinion that

direct or indirect payment to professional vendors should be discretionary for each case rather than to have direct payment a fixed provision under which federal assistance is received. In that event, direct payment to a beneficiary would be made as long as he demonstrated proper responsibility and carried out his obligation, thus preserving the self sufficient status of the individual. When it became apparent that a certain beneficiary was not to be relied upon to fulfill his obligations he would be denied the privilege of self payment for services, and these payments would be made for him directly to the vendor from which he contracted services. No reasonable person wishes to embarrass a welfare beneficiary because of his status; responsibility, however, may rightly be expected. There is some reason to believe that the next regular session of Congress may take some steps to revise the foregoing interpretation of the Social Security Act.

DIVISION OF STATE AID AND COLLECTIONS

This division handles reimbursement to towns of monies spent in the care and support of persons not having legal settlement in any Connecticut town. It protects the financial interest of veterans and others who are patients in state institutions and deals with the conservators, administrators, and other fiduciaries of the estates of mentally ill patients. It transfers recipients of public assistance to other states and countries where they properly belong and, in turn, receives persons properly belonging in Connecticut. In addition, it collects money for the care of patients in all state tuberculosis sanatoria, hospitals for the mentally ill, training schools, and hospitals for payment to the State Treasury. This division is financed entirely by public funds of the State of Connecticut.

Beneficiaries total 5,203 who are without any town settlement and consequently state charges. 2,128 of these are in institutions.

WELFARE MEDICAL CARE

The 1943 General Assembly provided for the payment of medical and hospital expenses for Old Age Assistance beneficiaries. In compliance with the bill, Commissioner of Welfare Robert J. Smith and Medical Advisor Dr. Leonard Parente formulated the medical program. A general advisory committee was appointed, consisting of a prominent business man and representatives of the State medical, dental, and hospital groups. Later technical advisory committees were appointed within e professional category. It was these groups meet with representatives of the Welfare Departm who set up the cost standards which are curren in use in determining payments of the Welf Department to private practitioners. It is to be no that these cost standards were not arrived at e pirically, but resulted from lengthy and exhaust studies of the problem.

In 1943 Commissioner Smith estimated that t medical care program would cost about $1,000,0 The welfare rolls at that time contained over 37,0 individuals. In the last fiscal year, 1946-1947, w but 34,000 beneficiaries, the cost of welfare medi care was $2,838,590, an increase of almost 200 p cent. A complete breakdown of this over-all me cal cost to show its exact distribution is not ava able. Several group classifications, however, sh the general division of expenditures.

Physicians	$ 269,363.80
Hospitals:	
State Aided	299,236.56
Non State Aided	100,318.80
Convalescent Homes	1,819,234.84
Dentists, nurses, clinics, outpatient departments, optical care, ambulances, drugs and appliances	350,436.62
Total	$2,838,590.62

PHYSICIANS

It will be seen from the foregoing that the amou paid to physicians was a substantial figure a represents a source of income to the practition that must be significant. The amount appears have been expended evenly between specialists a general practitioners. The beneficiary is permitt free choice of a physician who may be called any time without prior authorization from the We fare Department. Professional calls for chronic il ness are usually limited to one per week unless acu illness intervenes or unusual circumstances develo While other states often require rigid checkin systems to insure that patients are not overvisite by physicians, we have been content to rely upo the integrity of the doctor rather than to add to h clerical burden with elaborate authorizations an safeguards. The Welfare Department only requir that the physician present an itemized bill in accord ance with the charges agreed to by his medic society. There has been some abuse of this freedo which has necessitated investigation of the indivi ual case.

HOSPITALS

Certain hospitals in the state, some 32, which include most of the large hospitals, are known as state-aided hospitals since they receive certain grants from the General Assembly. These grants are subsidies which were originally intended to reimburse the hospital for the care of indigent patients. In recent years, in addition to these grants, the hospitals are now paid at a per diem rate fixed by the General Assembly. On October 1, 1947 it was increased from $4 to $5 per day. With these facilities available, all welfare cases requiring hospitalization for either medical or surgical treatment should be sent to one of the state-aided hospitals. Only when in a hospital is not within reasonable distance for emergency or space is not available, are welfare cases hospitalized in non state-aided institutions. The latter group are paid a per diem rate which is agreed upon between the hospital and the Office of Commissioner of Welfare.

CONVALESCENT HOMES

It is readily apparent that this is the most significant item of the medical care program. The above care represents ordinary nursing or custodial care, and all visits by physicians or other professional expenses are in addition.

PRESENT DIFFICULTIES OF THE DOCTORS

From the physician's point of view, two main difficulties have come to the attention of the Welfare Department. The first is the failure of the doctor to receive payment for his services which were properly rendered to beneficiaries and billed according to the existing fee schedule. The reason for the difficulty has been pointed out in the foregoing, and it is hoped that within a short time we will be able to guarantee the payment, either by the beneficiary or by direct payment to the doctor. Until such a procedure is instituted, the Welfare Department suggests that any doctor who does not receive payment from a beneficiary notify the proper division of the State Welfare Department of the fact. If he is informed that the patient has been paid as was outlined in the procedure above, he should contact the beneficiary. If payment is still not forthcoming, he should again notify the Welfare Department that such is the case. Steps will then be taken to remind the patient of his indebtedness and payment to the physician will be forthcoming.

The second difficulty has been in the matter of fees. The department has received complaints from time to time from individual doctors and from local societies that they had decided that they could not and would not take care of Welfare Department beneficiaries according to the existing fee schedule. That is certainly their right and privilege and there is no compulsion by the Welfare Department on any physician to participate in its medical care program. The matter of fees is at present under revision and an attempt is being made to establish uniform fees for the same specific medical service throughout the state when such service is rendered to any beneficiary of a state department. It does not seem reasonable that a doctor who treats a specific ailment for one state agency should be entitled to more money than a doctor who treats the same ailment for another state agency. Presently the state agency representatives will meet with the representatives of the State Medical Society to establish a new fee schedule. When a tentative schedule has been approved, it is felt that it should be presented to the county and local medical societies for their approval so that when the schedule is placed in operation there should be no further disagreement between individual doctors and the Welfare Department. No physician is obligated to take care of welfare cases beyond his obligation to care for any sick person, but if he does take care of welfare cases, he is obligated to perform such services in compliance with the agreements with the Welfare Department which have been entered into in his name by his duly appointed representatives from the various societies.

PRESENT DIFFICULTIES OF THE WELFARE DEPARTMENT

The Welfare Department is fully aware of the excellent relations which have existed between itself and the organized medical groups. It takes advantage of this opportunity to express its sincere appreciation to the great majority of doctors who have never stinted their time or ability in the care of its beneficiaries; to whom the fee difficulties have been a secondary consideration and consigned to that bottomless pit where rest so many other hard earned and unpaid medical fees.

There have been complaints from beneficiaries, however, that certain doctors, with full knowledge that the patient was a welfare beneficiary, have treated the patient only on the basis that the patient would pay the difference between the welfare fee schedule and the prevailing current rate in that particular office. This practice is indeed questionable and can reflect nothing but discredit upon its perpetrators. If the physician involved is a member of

the State Medical Society, he is violating the agreement of his society with the Welfare Department and, in addition, he is receiving two fees for a specific treatment. On moral grounds justification for this practice would be difficult. The welfare beneficiary subsists entirely on an extremely low income from the State and, as has been noted previously, any medical expense is paid for by an additional check to prevent the beneficiary from having to use what little substance he has in order to take care of an unforeseen illness. When the doctor requires his patient to pay a fee in excess of that which the Welfare Department will reimburse the patient (and reimbursement will only be in accordance with the fee schedule) the physician is taking money from the beneficiary which was given to him to cover his needs for bare subsistence. Surely there is no doctor in Connecticut whose income is so reduced that he must penalize these unfortunate people who desire his treatment.

A second major difficulty is the fact that many patients are given expensive treatments in the office which properly should be done in a state-aided hospital at no added expense to the Welfare Department, since our statutory rate there is all-inclusive. Some of these cases undoubtedly occur because the beneficiary does not make his welfare status known to the doctor as he is required to do; if he does not, the doctor, assuming that he is a private patient, performs the service in good faith. When request for payment is presented, the department finds itself embarrassed because provisions are not made for payment of private surgical procedures other than nominal first aid. The department is exerting every effort to make every welfare beneficiary aware that all types of medical care are available but that they must be secured in the proper place and since state aid is granted to certain hospitals, that is the proper place for such care to be given. We would like to suggest that any doctor who suspects that a patient is a welfare beneficiary but does not wish to risk embarrassment by direct inquiry may determine the exact status by privately phoning any of the four district offices of the Welfare Department in Hartford, New Haven, Bridgeport, or Norwich. If this difficulty could be overcome, it would remove one of the greatest sources of complaint between the physicians and the Welfare Department.

There are frequent requests to the department that patients be hospitalized in out-of-state institutions for treatments which in our opinion may be a- quately given in several Connecticut hospitals. some occasions we have no knowledge of the ma until we receive bills from patients already h- pitalized in such institutions. While there are c- tain diagnoses which conceivably may receive be treatment at certain centers in other sections of country, these are relatively few and the excell hospital facilities which exist in the State of C necticut should be utilized to the maximum. Unus cases which usually comprise this group should hospitalized locally if possible for the edification Connecticut physicians. Areas of the state wh border on large medical facilities of adjoining sta should not, of course, compromise the care of patient by insisting on hospitalization in Connecti where time is a factor.

Most fee schedules which deal with surgical c provide flat fees for overall treatment regardl of the number of visits or the length of time volved as long as no complications develop. W have noted cases where office treatment of lace- tions, abscesses, et cetera, have been billed on individual visit basis, which has resulted in an u- reasonable fee.

On several occasions welfare beneficiaries w or without revealing their status have been giv elaborate treatments which are not contemplated the welfare medical care program. It has been a is a basic premise of the department that we w provide our beneficiaries with a high standard medical care for care and treatment of illnesses a essential surgery. We do not feel that procedu which are purely cosmetic or merely desira should be a part of our program. In so far as we a able we do not propose to provide a better type care for a welfare beneficiary than a man who wor for a living is able to provide for his own family. do so would put a premium on welfare membersh and we never intend to make welfare beneficen more attractive than self-support. To some exte this situation actually exists now and it is a freque observation of those who study the problem th those who are not self-supporting are able to secu medical care and hospitalization without cost themselves while the employed person finds hims brought almost to the welfare level by the appalli costs of chronic illness. This situation, however, due to factors that are beyond the control of t welfare department.

WHAT IS THE DOCTOR'S OBLIGATION TO WELFARE BENEFICIARIES?

The answer to this question is a principle that must be clarified. At the moment it is unanswered, but as we have attempted to show in this paper, the welfare problem, already a multi-million dollar business, is growing constantly. Before any well founded, enduring medical care program adaptable to the increase in the welfare population can be instituted, the basic principle of the obligation of the doctor to welfare beneficiaries must be established. We shall not undertake any lengthy discussion but merely point out the two obvious views and each individual doctor should consider them to crystallize his personal feelings. At such time as a revised fee schedule is brought to his attention he should express those feelings in order that the ultimate working basis between the department and the physician will be sound and workable. The two views are simply these: first, that the welfare beneficiary should receive his medical care on the same basis as he receives his rent, food, and clothing; at the ordinary rate which is paid by individuals in the average income group throughout the state; second, that the welfare beneficiary is considered an unfortunate individual who for one reason or another has come to rely upon the welfare department for subsistence, and, being in this category, he is entitled to receive medical care at a lower rate than a person would pay who was self-supporting. This latter view is also influenced by the fact that such medical costs as are paid are derived from public funds, which implies that the greater the cost, the more the individual who receives payment will have to contribute to provide the funds from which the payment is drawn. These two views are quite opposed, but the first would seem to relegate the medical profession to the status of a trade, while the second would be more in keeping with the traditions of the profession.

CONCLUSION

Welfare medical care is an exceedingly complicated problem which will become increasingly important to the practice of medicine as time passes. To maintain a well operated, adequate program for medical care at a reasonable cost is the goal of the department. We are not interested in a cut-rate brand of medicine; we are not in a position to demand any specific type of treatment for any specific fee from any individual practitioner. We can only present the problem to the physician and accept the rates at which he will provide the necessary care.

Further, care of the indigent has always been a cornerstone of medical practice that has brought only gratitude and respect to the profession which has been amply reflected in the esteem in which the doctor has been held by the community he served. It was not without reason that Stevenson paid medicine one of its finest tributes:

"There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization . . . Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what is more important, Herculean cheerfulness and courage."

SUMMARY

1. A brief outline of the scope of the activities of the Office of Commissioner of Welfare and the welfare medical care program is presented.

2. The limiting provisions of the "direct money payment" principle, upon which federal assistance is contingent, are explained.

3. Certain current difficulties of both the physician and the welfare department are pointed out.

4. Some basic considerations which effect the current revision of the medical fee schedules are noted.

5. The question of the physician's responsibility to the welfare beneficiary is raised.

THIS IS GENERAL PRACTICE

W. W. Rieke, M.D., *Wayzata, Minnesota*

What is general practice really like? It is a progressively building-up process. It is more like a way of life than a sharply scientific pursuit.

The general practitioner or family physician is essentially the confident of his fellow men. To be successful, he must gather to himself a reputation for integrity, morality, understanding and the healing skill. He must have and feel at home in his laboratory. Checking laboratory routine should not be a bore. It should be a happy break in the office routine.

Let me take you through my office, which I believe compares reasonably with other offices in suburban areas. A goodly number of you will recall the general layout, having attended the opening in 1940. But to refresh your memory, the office is on the second floor on the main street with a side entrance (parking is free and available); the waiting room is shared with a dentist. There are 987 square feet of floor space, which consists of a waiting room which will seat twelve people comfortably, a business office, private consulting room, laboratory, examining room, children's room, x-ray and dark room, cloak closet and lavatory.

The furnishings must be and are in accord with the dignity of a professional office. Equipment consists of an x-ray machine, fluoroscope, electrocardiograph, and basal metabolism rate, diathermy, infrared, and ultraviolet machines, routine urine equipment including phenolsulphonepthalein; blood equipment including stains, blood sugar, sedimentation rate; hyphrocator, and cautery; and autoclave, which, incidentally, has taken the place of a sterilizer. The instrument cabinet is complete for minor office surgical routines, adequate tinctures, ointments, vials and ampules, tablets and capsules for office treatment; medications, outside of aspirin, are not dispensed. Office personnel includes a graduate nurse and a bookkeeper.

In order to acquaint you with daily routine of a general practitioner, I have taken four weeks at random out of the last year's practice and hav broken them down into the different phases medicine with which I come in contact.

Total patients seen during four weeks: 884.

Hospital visits	108
House calls	88
Surgical	174
Medical	266
E.E.N.T.	60
Pediatrics	112
Obstetrics	100
Gynecology	56
Skin	40
Nervous and mental	3
Genito-urinary	15

In order not to be overwhelmed by the abov the family physician must feel at home in his offic In the operating room the general practitione should not only be qualified but also should serve a an intelligent assistant to a specialist surgeon. Hi judgment and dexterity in the care of minor surgi cal problems should compare with specialists. H must be competent in caring for simple fracture cervical cautery, chest aspiration, et cetera. He mus have the use of fluoroscopy and know when t employ a radiologist. He must know obstetrics, in fant feeding, communicable diseases and skin; elder ly patients must be guided through degenerativ diseases, and death made a less harrowing experienc to relatives.

Consultation now comes into the picture. Durin the past year surgical consultations have been re quested of seven different men:

Medical	5
Pediatrics	5
Orthopedic	4
Obstetrics and Gynecology	3
Skin	2
Nervous and mental	4
Genito-urinary	3
E.E.N.T.	6

This is a total of thirty-nine men who have helpe in forming final opinion and aiding in treatment.

Presented to the staff at Abbott Hospital Staff Meeting, December 2, 1947
Reprinted by permission, Bulletin of the Hennepin County Medical Society, December 1947

How is consultation called?

1. If the family have preference, and I am reasonbly sure that their preference is qualified, their hysician is called.

2. If the decision is left to me, several factors nter into the choice: mechanical ability, diagnostic bility, personal approach to individual patients. I elieve that proper personal approach to individual ases can be the difference between complete rebvery and invalidism.

As one goes along in daily routine, natural pride differential diagnosis and case work-up is such hat, when consultants are called, it is only necessary hat his impression be verified. It, therefore, beooves the general practitioner to become more roficient at differential diagnosis.

The failure of the general practitioner to observe mitations of his training is a serious criticism—that me general practitioners fail to refer patients eeding specialized care may be attributed to their ear of loss of prestige and loss of income, and of he two, prestige is the more important. The indoctination of the public and the young physician with he idea that the specialist is a vastly superior being to a large extent responsible for the fear of loss f prestige and probably leads many general practitioners to try to create an illusion both to themelves and to the public that they are more or less pecialists. The answer to this lies in the improvement of the status of the general practitioner and is indoctrination with regard to the dignity of his osition as a family physician.

It is a matter of record that of the 160,000 practicing physicians in the United States today, only 0,000 are certified by various specialty boards; that a ratio of 1 to 8. Numerous men have stated, and believe correctly, that 85 per cent of the people eeking medical care can be scientifically and successfully treated by an intelligent family physician.

During the past fifty years, life expectancy has een increased from thirty-three to sixty years. Iaternal and infant mortality have been lowered remendously; many infectious diseases have all but een eliminated and numerous other strides have een made. If it is true that 85 per cent of medical are is given by the general practitioner, we must dmit that he has been quite successful in bringing he advances of medical science to the patient; urely this must imply that he is capable.

From an economic standpoint we cannot expect he majority of families to call in a pediatrician for treatment of a cold and then call an internist the same day to prescribe for the adults who are afflicted with the same illness; nor can they afford the orthopedic or obstetric fee that rightly should be charged by men of advanced training for routine sprains, simple fractures and normal deliveries.

I have gone into the above discussion at some length for two reasons:

(1) to remind you that the general practitioner has a specific and very important place in the present-day care of people; (2) to plead for recognition of the family physician on a plane comparable with other specialty boards.

I am sure we must all agree that there has been a trend toward specialized training both in the medical school and in every phase of postgraduate training. This emphasis has been very acute and certainly rather cutting to the position of the general practitioner.

Can medical schools conscientiously send out a man with only an M.D. degree, if they feel that he is not qualified to treat patients until he becomes certified by a specialty board? It is unfortunate, but true, that the teacher often uses his contempt for the general practitioner as a substitute for humor. This is unique; most people attempt to hide their failures.

Sir Robert Hutchinson once stated that specialization is inevitable, but though favorable to the accumulation of facts, it is bad for the philosophy of knowledge. There is too little speculation and too little use of the imagination and most scientific literature is barren of ideas.

If medical education is to progress, it is imperative that men holding key positions in educational centers shall be men not only interested in research and routine teaching but also in general philosophy and approach to individual clinical problems.

Returning veterans will admit good care while they were in the armed forces, but often state, "They didn't pay any attention to me." The family physician in the ordinary non metropolitan area, has as an inherent part of his daily routine the most important requirement, other than skill and technical knowledge, needed in the treatment of a patient. This is the simple but detailed and comprehensive knowledge about the patient, his family and background, his environment, his ambitions and hopes and the threats impinging against them. This is a contact which practitioners in large cities so often lose. This is what the psychiatrist, with strangers for

patients, spends months painstakingly attempting to evaluate.

Far be it from me to tamper with the curriculum of the medical school. As I look back on my four years of campus life, my main recollection is of insufficient time to absorb even the basic fundamentals. I must admit, though, that my elective courses in psychology, sociology and philosophy have formed a more sound basis for practical reasoning than the worn out and uninteresting courses in physical and physiological chemistry, which were a must. In the two clinical years, I recall a yearning for therapeutic conferences comparable to pathology conferences, but there seemed to be a mysterious evasion of honestly mapping out a program of treatment.

What further can be done to retain and improve the present status of the general practitioner? What has medical school done to prepare men in general practice? I believe that recognition of the general practitioner by the regimented systems would do much to improve his status in the minds of patients and young physicians. I believe that the general practitioner has a definite place on the staff in teaching centers. Here he could act as an advisor to the department heads, pointing out what parts of their specialties should be emphasized in the training of a general practitioner. This would eliminate the situation where, e.g., a future general practitioner completes his internship knowing well how to assist at a spinal fusion, which is of little value to him, but knows very little about differentiating between a sprain and an internal derangement of the knee joint, the differentiation of which may save some future patient of his a permanent disability.

One might even go so far as to establish general practitioner services in teaching military and veterans' hospitals. These services could handle the routine conditions usually handled by the general practitioner in his community in private practice.

I believe this would be valuable, both to the specialty groups and the future general practitioners, and would again enhance the prestige of the general practitioner in the minds of both patient and young physician.

The Veterans Administration states they wish to make their hospitals as much as possible like teaching centers. The above suggestion, I believe, would be a noble experiment. The fact remains that there are 19,000,000 veterans and their families who need to be reinformed and re-educated to the fact that private practice is essential to the American way of life. We, in general practice, challenge the specialty groups to form a bond with us to so care for the vast group, that socialized medicine will find not only professional lobbies, but laity lobbies fighting it. Postgraduate training for the general practitioners is exceedingly important and should be comparable to training for the specialties. To date very little has been done regarding standardization of postgraduate training.

I believe that a minimum of two years must be spent in hospital training. This time should not be spent in one institution. General hospitals present a grand opportunity for training in emergency care. Hospital admissions and the beginning of out patient services, obstetrics, pediatrics, contagion, skin, nervous and mental, the fundamentals of medicine and minor surgery must of necessity be picked from a teaching hospital. But there is more to hospital training than can usually be found in the general hospital. I believe that the private hospital must be included in this training—where case No. 100932 is not simply an interesting case of carcinoma of the colon with metastasis, but is Mrs. Jones, the mother of four children, who has a far advanced malignancy. In such a case finesse and graciousness must be used to help share the pain and grief, and intelligent counsel must be given to relatives who must carry on in the event of the departure of a loved one.

A third year should be spent in a preceptorship. At present there are numerous men or small groups, two to four men, in general practice about the state whose type of practice fits well into the general practitioner program. The young graduate could well afford spending six months in two different communities. Three years properly spent in this manner with careful examinations, written and oral, at its termination should send the young man out with understanding and confidence to care for people who entrust themselves to him.

One of my prize possessions is membership on the staff at Abbott Hospital. Hospital affiliation is as important to the suburban practitioner as a saddle is to a jockey at the Kentucky Derby. What should be the extent of hospital usage by the general practitioner? I do not believe that any man, specialist or general practitioner, can be approved or disapproved on qualifications only. There is a wide difference between qualifications and ability. During the fifteen years that I have observed technique and

spital routine, I can truthfully say that certain ocedures are performed with equal ability by rious groups of men, whether they be board certi-d or not. I am not particularly impressed by the kindly approach of some of our colleagues to the rsing staff. If their own daughters were as ruth-ssly approached by some other professional group, ey, as fathers, would be up in arms to the extreme possible bloodshed. However, if intelligence otients, education, and social standing were com-red, there would be very little difference between rses and daughters.

On the other hand, I believe I am right in sur-ising that the hospital should be dedicated to the re of sick people and a workshop for the physi-an. I am not at all sure that the past five to seven ars have calloused the average hospital away from is primary function. There is too much evasion d beating about the bush, and too little honesty tting at the root of service problems. If the indi-dual physician were guilty of one-tenth of the regularities which are committed by the hospital staff from day to day, he would not only be tre-mendously humiliated but could take an indefinite leave of absence.

I realize that the preceding remarks are rather bold statements of fact, but they do form a basis for a final plea for more proficient care of people. I am sure that the specialty groups are just as sincere in their fight against regimentated medicine as the gen-eral practice groups. It then behooves them to come to the rescue of general practice in a constructive way. Plain team work will make for greater effi-ciency. Hospital management needs to revive service in the minds of personnel so that hours per week need not be spent by the individual physician apolo-gizing for some uncalled for incident, or missed medication or haughty word.

In closing, I would say that the thoughts com-piled in this paper are my own. Numerous hints on phraseology have been gleaned from the British, Canadian and American literature, an index of which is on file at my office.

PROMINENT PHYSICIANS IN EARLY FAIRFIELD

Dr. Jeremiah T. Denison

Dr. Denison lived in the Colonial House on the st side of Beach Road 520 feet south of the Old ost Road in Fairfield. This house was built by athan Bulkeley, (1718-1783) before the Revolu-on. It has a plain pitch roof; was shingle, now clap-oard. This is one of the houses used by the British mess house and quarters at the time of the burning f Fairfield, and so was saved from the conflagra-on. Bulkeleys and David Judson, town clerk, lived ere, as does the present, 1948, Town Clerk, Samuel lover. The house was willed by Esther Bulkeley dson to the wife of Dr. Denison.

This eminent gentleman gave real distinction to e town. Born in 1806, the son of Capt. Henry enison, he graduated from Yale in 1824, and then evoted himself to medical and surgical science in aris and London where he took his degree in medi-ne in 1827. For forty years he was known as a successful physician in Fairfield and in the State.

Dr. Denison relates that when he began practice in Fairfield he was called to a home some two miles distant. After attending the patient he was asked what was the charge. He stated twenty-five cents (half-price, as he thought, from appearances, they were poor people) which they paid him daily till his patient recovered. The doctor found in a day or so that he had been deceived by appearances, as they were quite wealthy for the times, but studied to avoid care and labor.

About twenty-five years before his death the principles of homeopathy were pressed upon his attention, and his earnest and rigid investigation resulted in his adoption of Hahnemann's system of science, for which he underwent relentless persecu-tion. In 1851 he was elected to the presidency of the Connecticut Homeopathic Society. Genial, sympathetic, cultured, a gentleman of the old school,

ourtesy of Fairfield Historical Society



Home of Dr. Jeremiah T. Denison
Erected by Nathan Bulkeley before Revolutionary War
Saved from the burning of Fairfield

he lived a very useful and fruitful life. He died in the Bulkeley house in 1879 in the 74th year of his age.

2. Dr. David Hull (1765-1834)

The name of Dr. David Hull also is one of affectionate remembrance to the inhabitants of Fairfield, among whom he was the leading physician for many years. He was the son of Joseph and Elizabeth (Clark) of Derby. He graduated from Yale College, 1785, and studied medicine in Boston. In Boston he married Susanna Eliot, the daughter of the Rev. Dr. Andrew Eliot, and settled in Fairfield where he died at the age of 70 years. His daughter lived in the Colonial house at the Southeast corner of Beach Road and the Old Post Road, built in 1790.

3. Dr. William Burr Nash (1743-1815)

Dr. Nash studied with Dr. David Hull until 1807 when he was licensed to practice. He married Ruth, daughter of the Rev. Andrew Eliot, of Fairfield, a settled in the house in Greenfield Hill former occupied by Dr. David Rogers, a physician of co siderable celebrity. Later Dr. Nash moved to Fai field proper and entered into partnership with D Hull. His son, M.D. at Yale in 1835, began his pra tice with his father who had moved to Bridgepo At the period when Dr. Nash entered profession life applicants to practice medicine were examin and licensed by a committee of physicians, and t degree of M.D. was not worn by them. Yale co ferred the degree on Dr. Nash later. Dr. Nash w also a trustee of the Fairfield Academy in 1825.

4. Dr. Ebenezer Jessup (1739-1812)

Dr. Jessup was a physician of high repute and brave and distinguished surgeon in the War of t Revolution. He was surgeon in the Crown Poi Expedition, October 1762, and surgeon to Co

ticut Troops, October 1777. Graduating from le in 1760 he married in 1764, again in 1774, and the third time in 1792. Living on the homestead Greens Farms and practicing extensively as a ysician, he was also deacon in the Greens Farms urch for twenty-four years.

Dr. Francis Forgue (1730-1783)

One of the most prominent physicians during the volutionary War period was Dr. Francis Forgue, rn about 1730 and called "Late useful Physician." had married the charming widow of Mr. Dennie, d lived in the home left to her by her first hus- nd. Dr. Forgue served as surgeon, 7th Regt., my, July, 1775, and died in 1783 in his fifty- urth year. He was naturalized, May 1774, being led a native of Toulouse, France, now of Fair- ld. His son, Francis, Jr. was born in this Colony.

A foot-note gives the following: "Francis Fogue, gitimate son of Ann Durand, was bapt. at Derby, Apr. 1766. Dr. Francis Fogue died at Naugatuck, or 28 February, 1825, age 58; the church record s of him, 'he had imbibed infidel sentiments, de light of death, caused coffin and gravestone be prepared long before his death and directed t the band of music should play at his funeral. other respects the solemnity of his funeral was served in the usual manner.' A child, Mark- ancis, is given as born 3 Aug. 1767 according to Bible record.

Dr. Forgue's son, Francis, soon after the Revolu- n established the first printing press and news- per in Fairfield, called the *Fairfield or Independ- t Gazette—The Intelligencer.*

Dr. Isaac Bronson (1759-1838)

Dr. Isaac Bronson, surgeon of the American my during the War of Independence, a friend of ashington, later a prosperous banker and finan- r, made his home on Greenfield Hill. Soon after . Timothy Dwight removed to New Haven in 95, Dr. Bronson purchased the Dwight property, quarter of a mile below the Greenfield Church. n both sides of the street he built attractive stone lls and set out double rows of white-flowering gwoods along the highway. Today, the dog- oods on Greenfield Hill number into the thou- nds, surpassing in beauty anything one can agine.

Dr. James Laborie

In 1718 a very interesting and valuable acquisition the society of Fairfield was gained in the person of Dr. James Laborie. He settled at Stratford in 1703. For his usefulness as a surgeon of the Connecticut troops in her Majesty's service he was granted by the General Assembly three shillings and four pence per day. He was appointed, with Dr. Samuel Mather, surgeon of the Connecticut troops against Port Royal; was paid forty shillings for his good services against Port Royal, and was granted ten pounds a month in money for his services in the expedition against Canada, "a suit of regimental clothes gratis," and one month's pay in advance. His medical diploma, dated London, 1697, which was recorded by the Clerk of the Fairfield County Court in 1713, is written in Latin, and represents him to have been the son of a celebrated physician of France. In 1718 he purchased of "Mr. Isaac Jennings the stone house on the rocks" (the property on which Roger Ludlow High School now stands), which, in a letter to the Secretary of the Church of England, he says "he had destined to the service of the Church of England." On the town records we find the following vote: "Dec. 16, 1718. The town grants unto Dr. Labarree ye ups of what land he enfenced ajdoining to his orchard in Fairfield during ye town's pleasure."

No sooner had Dr. Laborie settled in Fairfield than he began the labor of Christianizing the Indians in this region. He also gathered such persons as favored the Church of England at his house on the Sabbath, and with them used the services of the Church. He won the respect and confidence of all who became acquainted with him as physician, soldier, and sincere Christian. The General Assembly mentioned him "as a gentleman of great skill and practice." Dr. Laborie died in Fairfield in 1732. In his will dated March 17, 1731, he gives to his son James all his surgical instruments & all his French writings. His son practiced medicine in Stratford.

8. Dr. Rufus Blakeman

Dr. Rufus Blakeman was fifty years a physician in Fairfield, and for twenty-four years Probate Judge. He was a graduate of Yale and descendent of the Rev. Blakeman of Stratford. He built his home on Greenfield Hill, on the west side of Bronson Road, 300 feet south of the Green. The deed and builder's receipts are dated 1822. He was an abolitionist and the secret room in his house was for the Underground Railway. In 1853 he delivered an address before the Connecticut Medical Convention. He was one of a committee appointed in 1845 to superintend and oversee the building of the new

meeting-house which the Greenfield Church Society had agreed to build. The old meeting house was pulled down all at once. Everything was sold except the pews, stepping-stones, and lightning-rod, and the money applied to the building of the new church. The weather-cock vane was sold to Samuel Grant to be melted up for the lead it contained, one glass eye only being rescued by a son of Dr. Blakeman, and still treasured at the old homestead. Rufus Blakeman was a subscriber to the new meeting-house, and his wife contributed 4 loaves of cake to help feed the men who raised the church.

9. Dr. Hosea Hurlburt

Dr. Hosea Hurlburt also lived on Greenfield Hill and was a surgeon in the Connecticut Continental Line. At the time of the Danbury raid, Hurlburt put his horse over the back stone wall and escaped but with a shot in his saddle bag. He was a scholar and aptly quoted poetry and the classics, and was very keen at repartee. Dr. Hosea Hurlburt was the first known occupant of his house which was built in 1754 and is now one of the interesting homes on Hillside Road.

Physicians

The One Hundred and Fiftieth Anniversary Celebration Pamphlet of Greenfield Hill mentions the following physicians: Dr. John Hyde, Elipha Hull, David Rogers, Aaron B. Bradley, Daniel W gins, Hosea Hurlburt, William B. Nash, John Paterson, George Dyer, Rufus Blakeman, James Kissam and Martin V. Dunham. There were oth who were born in Greenfield but who practised various places: Drs. Thomas Bradley, Willi Wheeler, Ebenezer B. Belden, Nathan Baulkl John Nichols, David Nash, Nathaniel H. Freem George B. Banks, Moses Wakeman, Ranson Ly William R. Blakeman, Nathan Wheeler, and Geor Nichols.

And the late Samuel M. Garlick, father of D George B. Garlick, lived and practiced in Fairfie and was on the Board of Trustees of the Old Fa field Academy.

BIBLIOGRAPHY

The History of Fairfield, Fairfield County, Connecti from 1639 to 1818, by Mrs. Elizabeth Hubbell Schenck.

History and Genealogy of the Families of Old Fairfie by Donald Lines Jacobus.

A List of Eighty-seven Old Houses in Fairfield, Connecti Published by the Fairfield Tercentenary Committee, 19

Transactions of the One Hundred and Fiftieth Anniversa of Greenfield, Ct., Congregational Church, held May 1876.

History of Fairfield County, by D. Hamilton Hurd.

ANNUAL COUNTY ASSOCIATION MEETINGS

New London, Thursday, April 1

Seaside Sanatorium, Waterford

Business meeting 5:00 p. m. Dinner 6:30 p. m.

peaker: Julian B. Herrmann, m.d., New York City

ubject to announced

Hartford, Tuesday, April 6

Hunt Memorial Building and Hartford Club, Hartford

Business meeting 4:00 p. m. Social half-hour 6:30 p. m. Dinner 7:00 p. m.

peaker: Thomas J. Dodd, Attorney-at-law

ubject: "NAZI MEDICAL EXPERIMENTS PRIOR TO THE NUREMBERG TRIALS"

Middlesex, Thursday, April 8

Red Coach Inn, Cromwell

Business meeting 4:30 p. m. Dinner 6:30 p. m.

peaker: Gerald Klatskin, Assistant Clinical Professor of Medicine, Yale University

ubject: "THE RATIONAL USE OF LIVER FUNCTIONAL TESTS"

Fairfield, Tuesday, April 13

Stratfield Hotel, Bridgeport

Business meeting 4:30 p. m. Social hour 6:00 p. m. Dinner 7:00 p. m.

resident's Address: J. Grady Booe, m.d., "THE CARE OF RECTAL FISTULAE"

peaker: Honorable Brian McMahon, U. S. Senator from Connecticut

ubject: "PEACE IN ATOMIC ENERGY"

Litchfield, Wednesday, April 14

Charlotte Hungerford Hospital, Torrington

Luncheon 1:00 P. M. Business meeting Scientific program

President's Address: Winfield E. Wight, M.D.

Windham, Thursday, April 15

Nathan Hale Hotel, Willimantic

Business meeting 5:30 P. M. Dinner

Speaker: W. T. Vanderlaan, M.D., Assistant Professor of Medicine, Tufts College Medical School and Physician to the Pratt Diagnostic Hospital

Subject: "DIAGNOSIS AND MEDICAL TREATMENT OF HYPERTHYROIDISM"

Tolland, Tuesday, April 20

Place, speaker and subject to be announced

New Haven, Thursday, April 22

New Haven Country Club, New Haven

Business meeting 5:00 P. M. Social hour 6:30 P. M. Dinner 7:00 P. M.

Speaker and subject to be announced

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EDITORIALS

General Practice and the Specialty Boards

The desire expressed by general practitioners to establish a specialty board may appear somewhat absurd on first thought, but the thinking behind such a move calls for serious consideration. There is no doubt that the disadvantages felt by this group and often other non "board" members has developed into a situation not foreseen or contemplated by those who framed the original purpose of the certifying boards. That the non certified physician often is placed at serious disadvantage is seen in the operation of the appointment system used by certain government agencies and by many hospitals. As a result, recent graduates are making a demand for a resident type of special training which there is no possible way of satisfying. Hospitals offering such training find themselves deluged with applications for positions while many excellent hospitals without such programs are unable to fill their house-staff assignments. President Tresidder, of Stanford University, in discussing this question and the dangers which may be present stated recently, "There is real danger that the aggressive plausible man may work into house-staff positions to the exclusion of those of greater ability who wish to follow a less standardized course in the way of research or preparation for teaching, or practice. It is my impression that the house staffs in teaching hospitals are in a way of becoming 'cramming' schools for the boards." If these observations are cogent, and it is becoming increasingly apparent that they are, then serious attention must be given to the situation if medicine in our country is to continue to aim at assuming its proper social responsibilities. Further, if educational trends are taking these narrow lanes, then our educators and those responsible for medical training programs have heavy responsibilities indeed. The challenge that today faces not only medicine but other sciences calls for an understanding of social problems and a recognition of responsibility to modern society that many exponents of modern scientific training have overlooked. In medicine it is perhaps safe to say that the general practitioner, by tradition and by service, comes nearer to fulfilling these social obligations than his more "qualified" brothers. Furthermore, in many instances his knowledge and experience has been gained largely by his own initiative, the truest way to real education.

A question arises as to whether or not the student at graduation should be permitted to enter a specialty training program. Nevertheless, the idea that he should do so has been fostered to the extent that it has become largely the established thinking of third and fourth year medical students. It has been suggested that the boards themselves might seek to remedy this unhealthy situation by demanding that an eighteen months or two year rotating internship should be one of the requisites for admittance to examination. Such broadened training might have very beneficiary effects, not only on the individuals concerned but upon the whole intern training prob-

lem. Under it the young doctor would bring a maturity to his thinking, which unfortunately is lacking at present.

However, the dangers of overspecialization are not confined to medicine, for many of the "molding" practices which infiltrate our entire educational system call for a careful survey if we would avoid the dangers inherent in assembly line methods applied to the training of our youth. Let us hope that it is not too late!

Public Demand for Service at Night

The American Medical Association calls on county medical societies to meet the public demand for emergency medical service at night.

"From many sections of the United States," says an editorial in a recent (March 6) issue of *The Journal of The American Medical Association*, "complaints have come lately that persons who have called physicians late at night have been unable to secure attendance from either those whom they considered their family physicians or from specialists or, indeed, from any physician."

The American Medical Association says that large county medical societies or urban groups should maintain a physicians' telephone exchange which would take the responsibility for locating physicians if response is not made to the ringing of the telephone in the home or in the office.

The solution is simple and practical, requiring only a minimum of community organization. A number of county medical societies already maintain a physicians' telephone exchange where doctors' calls may be received and doctors located if their office or home telephones do not respond. Such an exchange can be utilized as at night or on holidays, simply by furnishing the exchange with a list of physicians who are able and willing to make night calls. Such physicians would probably include the younger general practitioners, newcomers to the community, and others in general practice. If such a roster were available, and its availability widely publicized, night calls for medical service would soon gravitate to this center and the patient would be assured the services of a physician.

Under such a system the necessity for calling many doctors would be eliminated. Two calls at most would be necessary. Where there is no physicians' telephone service, it might be possible to have the hospitals cooperate by handling such nig calls.

The Medical Society of the District of Columl and the Milwaukee County Medical Society ha found such a plan practical, as have a number other societies.

By this simple and practical expedient, which doubtless in effect in modified form in a number communities, the sick can be served and the me cal profession can redeem its pledge of unselfi public service.

It is highly important that where such arrang ments exist they be brought to the attention of t lay people in the community through appropria public channels, not once but repeatedly, to ke the shifting populations well informed.

Few problems in the field of medical service ha aroused so much public discussion. Whether reser ment against physicians is justified or not, it do harm. The solution for this problem is so eminent simple and would reflect so favorably upon phys cian-patient relationships that medical societi everywhere are urged to give it serious consider tion immediately.

A Healthy Place to Live

Recent statistics compiled by the State Depar ment of Health for the year 1947 show that Co necticut is a healthy State in which to live for th infant and maternal mortality rates, and the dea rates for tuberculosis, pneumonia, appendicitis an whooping cough for the past year were the lowe in the history of our State. For the second consecu tive year, the number of live births in the stat 44,494, established a new record, exceeding th previous year by 9.7 per cent. The birth rate itsel 23.5 per 1,000 population, was the highest since 192 when the rate was 24.2. Lower birth rates for th last two months of the year suggest that the curre peak was reached in 1947 and that the 1948 ra will decline. Deaths from all causes during 194 totaled 18,982 or a rate of 10.0 per 1,000 populatio which equaled the record low set in 1945. Th infant mortality for 1947, 25.0 deaths under on year per 1,000 live births was the lowest in th history of the state. The previous record was 28 deaths per 1,000 live births established in 1946. Th maternal mortality rate of 0.7 per 1,000 live birth also represent a new low for the state. There we

; puerperal deaths in 1947 compared to 38 the revious year. Dr. Howard's paper on this subject, hich apppeared in the pages of the April issue, ows the remarkable results which have been ob- ined in the field of obstetrics, a record which has ceived nationwide attention. Deaths from acute mmunicable diseases also show a low mortality. nly three deaths due to whooping cough occurred uring 1947, a new low mortality rate of 0.2 per o0,000 population. The number of deaths due to ther acute communicable diseases were as follows: phoid fever, 1; cerebrospinal meningitis, 6; diph- heria, 1; poliomyelitis, 7. There were no deaths om scarlet fever; the last year without deaths tributed to this disease was 1942. Considering the mportant causes of death, heart disease again leads he list with 357.0 deaths 100,000 population and ancer, 162.7. The cardio-renal-vascular diseases, hich include intracranial lesions, arteriosclerosis, nd diseases of the kidney in addition to diseases of he heart, accounted for 53.1 per cent of all deaths. Cancer was responsible for 16.2 per cent. The death ate from all forms of tuberculosis continues on the ecline with 26.8 as the lowest on record. New ow rates were also established for pneumonia, all orms, 27.9, and appendicits, 2.3.

The Committee on Prepaid Medical Care

The report of the Committee on Prepaid Medical Care which will be presented at the House of Dele- gates at the annual meeting of the Society will be received with great interest. This is probably the most comprehensive committee study which the Society has embarked upon and the time and effort which has been expended by those who serve is a fine example of devotion to our interests. Over the years of the Committee's existence a continual effort has been made to become acquainted with all aspects of this complicated subject. The recent con- ference held in New Haven on February 26 showed a keen interest taken by the representatives of hos- pitals, specialty groups and insurance companies. As in the special meetings of the County associa- tions many diverse opinions were expressed. There was evidence, however, in this meeting as in the others, of a general agreement that some plan of medical insurance for workers in low income groups should be developed. In addition to numerous con- flicting statements presented at the Conference there were also suggestions which undoubtedly will help the work of the Committee. Among these latter were questions involving the lowering of the income ceiling and the raising of charges for medical serv- ice. The question of a service contract was again thoroughly aired and it was pointed out that con- tracts of this kind were working successfully in the three states adjacent to our border. It was once more made clear that the present proposed plan is wholly a medical society plan and therefore is amen- able to modification at any time. No plans have been developed anywhere with more complete control in the hands of a medical society. Furthermore, the type of contract at present proposed is not with any insurance company, but with the public, giving to them assurance of what may be expected of the medical profession.

Upon those who will be members of the House of Delegates will rest a high responsibility for an all important decision: they and all members of our Society may be assured that the report of the Com- mittee will be the mature thought of those whose sole aim is to do what is best for the Society and the public that it professes to serve.

This is General Practice

Under this title Dr. W. W. Rieke of Minnesota writes with authority and conviction. Not the least interesting part of his paper is the fact that for the most part it reflects experience in our own state. His belief that 85 per cent of people seeking medical care in this country can be properly treated by the intelligent family physician should interest medical economists, some of whom have been inclined to discount the great importance of the general prac- titioner. Dr. Rieke also has an important message to those engaged in medical teaching, and for those responsible for hospital administration. His remarks concerning the relationship of the physician prac- ticing general medicine to the hospital staff are significant. We reprint this paper not only by our own editorial decision but on the recommendation of others who believe that it has a useful mission.

More on the Mission to Japan

A commentary on the Social Security Mission to Japan was made recently by Congressman Harness, chairman subcommittee on publicity and propa- ganda, before the Conference of Executive Secre- taries of the Indiana State Medical Association. He said, "It is a matter of public knowledge that the Health Mission to Tokyo has now returned to the

United States. They came back, be it noted, before Messrs. Altmeyer, Falk, or Cohen joined them in Japan.

"We are assured from certain events in the public record, that our subcommittee's letter to the House Appropriations Committee, under date of September 9, 1947 had a definite influence upon the course and actions of the Tokyo Health Mission. Once the full light of public inquiry and understanding had been focused upon the mission, it soon became a different sort of thing.

"You will be happy to know that General MacArthur has not acted on the recommendations submitted by this mission; but has referred them to the American Medical Association in Chicago for consideration and advice.

"I wish that I were free to give you at this time the details of the communications that have passed between myself and General MacArthur on this transaction. I cannot properly do so, however, until the final report of our subcommittee." The Mission to Japan and its aims was described by Dr. Marjorie Shearon in the December 1947 issue of the *Journal.*

Alcoholism

Recent scientific as well as popular literature has emphasized the concept that alcoholism is a disease. The impression is sometimes created that this idea is a new discovery. Actually, medicine long ago recognized that the compulsive drinker, however he was called, was a sick man requiring attention as a patient.

It is more than a century since the Connecticut Medical Society appointed a committee to inquire into the problem of the management of inebriates. In its report,[1] published in 1830, the Committee stressed the inadequacy of a system whereby the intemperate person could only "be sent to the workhouse for punishment." The Committee wrote, "Befor attempting to eradicate any disease, we should endeavor to investigate its character, to inquire into its nature and tendency . . ." There was no question in the minds of Connecticut doctors 118 years ago that alcoholism is a disease. It is of historical interest that this society was the first organized medical body to attempt to deal with the disease of alcoholism.

A notably complex disease entity, alcoholism h not yet yielded to the necessarily incomplete a proaches of the past. At least one impediment h been the emotionalism which traditionally surrounc the problem of alcohol. This factor has often di couraged scientists in their efforts and no doubt in part responsible for the indifferent progress mac until recently. The wide publicizing of the concep that alcoholism is a disease is therefore socially us ful. Acceptance of this concept by the general pul lic will render it increasingly possible for medicir and related sciences to assume the primary rol which should be theirs in the solution of the proble of alcohol.

The past two decades have seen truly fruitfu research in the field of alcohol problems. Physiolc gists and biochemists have combined their effort with clinicians to learn more about alcohol and it effects on the human body than was discovered i many preceding centuries. Hoary beliefs about th heredity of alcoholism and the hopelessness of th drunkard's fate have been weakened under experi mental techniques. Knowledge of the metabolisr of alcohol and of the diseases which affect th chronic alcoholic is now far advanced. The rol of nutritional deficiencies in the etiology of mos of the somatic and some of the psychiatric syn dromes common in alcoholism is widely understooc The physician today has at his command effectiv means to combat the bodily diseases of chroni alcoholism. Psychiatry, too, is increasingly demon strating its ability to cope with the abnormal menta states associated with excessive drinking. Neverthe less, the central problem of alcoholism is still wid open. Whether the alcoholic becomes a helples victim of the compulsion toward intoxication be cause of biological factors or sociological determi nants or both is a subject of current research.

Whatever the answer may be, society as a whol and physicians in particular are profoundly con cerned with the immediate problem of the alcoholic It has been recently determined[2] that in the State o Connecticut there are 928 chronic alcoholics pe hundred thousand adults. This is equal to more tha 11,000 men and women in the state with an alcoholic disease. In addition, it is estimated that there may be three times as many excessive drinkers who ar not marked by an alcoholic disease but some o whom will certainly enter the ranks of the chroni

1. Todd, E., and others. Report of a Committee of the Connecticut Medical Society respecting an Asylum for Inebriates. New Haven; H. Howe, 1830.

2. Jellinek, E. M.: Recent Trends in Alcoholism and i Alcohol Consumption. New Haven; Hillhouse Press, 1947

coholics unless the pattern of their drinking is anged.

The proper concern of Connecticut physicians th this disease is manifest in the invitation to the ate Commission on Alcoholism to present a sym- sium at the forthcoming annual convention of e State Medical Society on the afternoon of April . The State of Connecticut is in many respects in e forefront of contemporary activities aimed at a entific approach to the problem of alcoholism. Yale University the Laboratory of Applied ysiology is the center of broad research in medi- l as well as sociological and other aspects of the oblem. The Connecticut Commission on Alco- lism, established by an Act of the state legislature 1945, is carrying on an expanding program of cilitating medical treatment and social rehabilita- n of the alcoholic as well as research and educa- n with a view to prevention.

In the field of treatment the Commission now intains an out-patient clinic in Hartford under edical direction and, in addition, provides through ntractual arrangement for the treatment of alco- lic patients at the Yale Plan Clinic in New Haven. he work of these model clinics is one of the most omising advances in the management of alcoholics. diagnostic study of the patient is carried out to termine the specific kinds of therapy, medical and ychiatric, required in the individual case, and ese procedures are combined with social service d vocational rehabilitation. Similar clinics are ojected in other parts of the state and will come to being on the basis of careful planning and with e availability of suitable personnel.

The Commission has begun work on a hospital in artford which will provide 50 beds for the short- rm care of in-patients and an ambulatory clinic ith facilities for 400 patients a year. Funds for this spital have been allocated and a site has been ocured on Coventry Street opposite the Hartford cCook Memorial Hospital. The hospital is planned a pilot demonstration center for the treatment and habilitation of alcoholics.

In the field of education the Commission cooper- es closely with the Yale Plan program. The mposium which is to be presented at the conven- n of the State Medical Society is an example of e Commission's educational activities, directed in is instance to the doctors of the community. And e physician, indeed, requires further education if is to fulfill his proper function in the scientific approach to alcoholism. It is not enough to sober up an intoxicated patient, give him some sedation, inject some needed vitamins, and dismiss him with the admonition to quit drinking. The doctor must not be indifferent to the essential illness, the compulsion which makes it impossible for the alcoholic to stop without help. If not equipped personally to treat this compulsion, the doctor is the one who can most effectively advise the patient concerning the nature of his illness and recommend suitable measures for its treatment.

Scientific knowledge about the disease of alcoholism is increasing steadily. A scourge of mankind since ancient times, alcoholism now seems ripe for conquest. The Committee of the Connecticut Medical Society of 1830 aptly set the goal: "To relieve the sufferings occasioned by past habits of intemperance, and to eradicate the strong but artificial propensity." By adopting and encouraging a scientific interest in the study of the problem and by applying their professional skills in the management of the alcoholic patient, the doctors of Connecticut in 1948 can make a valuable contribution toward the eradication of alcoholism.

Governor James L. McConaughy

Medicine in Connecticut has lost another good friend and staunch supporter in the sudden death of the Chief Executive, His Excellency, James Lukens McConaughy. The news that he was a victim of that relentless foe, coronary occlusion, on the afternoon of Sunday, March 7, came as a shock to all.

The Governor's career since his graduation from Yale in 1909 has been one of service to his fellowmen. First as an instructor at Bowdoin College and graduate secretary of its Y. M. C. A., then as instructor at Dartmouth, followed by the presidencies of Knox College and Wesleyan University, he brought to his political career at the State Capitol a sympathetic understanding of his fellowman engendered by years of intimate contact with the problems of the college student. His spirit of altruism was evidenced by his active participation in such fields as the China Relief Organization. His service abroad during the last war in the Office of Strategic Services in itself was a sizeable contribution to his country.

Dr. McConaughy has been cognizant of medicine's problems and understanding of its needs. In

his letter to the physicians of Connecticut published at the time he assumed office in January 1947, he said, "I am grateful for the opportunity of again expressing, in behalf of the State of Connecticut, our gratitude to Connecticut's doctors for their leadership and devotion during the difficult war years. All of you were rendering 'war service' whether you were actually in uniform or not. Long hours, overwork, no vacations were your lot." One of his last acts was to drop in at the pre-campaign dinner of the Connecticut Cancer Society and show, as he said, by his presence there more than by his words his interest in the welfare of his people.

The passing of Governor McConaughy is the greatest possible loss to the physicians of Connecticut.

Annual Congress On Medical Education

A series of papers on the financial support of medical education provided one of the highlights at the annual Congress on Medical Education which was held in Chicago recently and which was attended by more than 300 deans, educators and state licensing officials. It was the largest attendance on record.

All of the speakers agreed that if the present high standards of medical schools are to be maintained and if further advances are to be achieved, greatly increased financial support of medical schools is needed without delay.

Dr. Alan Valentine, president of the University of Rochester, stated that while budgets of the medical schools today are in excess of 43 million dollars, the schools will need to increase their budgets by at least 40 million dollars more if they are to train students adequately in all phases of medical science.

Dr. Valentine and the other speakers on the program appeared to be unanimous in the belief that if a free and unfettered progress in medical education is to be maintained, the privately supported schools must continue to receive generous private support. Federal funds for medical education, except on a short term emergency basis were considered undesirable unless all efforts to secure private support failed.

Dr. Valentine pointed out that the additional 40 million dollars needed by the medical schools represents only 1/6000th of our gross national income and that it is 1/5 of what Americans spend annuall on vitamin pills and less than 4 per cent of wh Americans spent on jewelry in 1946. He also pointe out that from 1932 to 1944 the national income ro from $60 to $242 billion dollars. These figures ind cate that there is in private pockets more tha enough to finance painlessly the added costs medical education.

Foreign medical education received considerabl attention during the congress. The Committee o Foreign Medical Credentials held a meeting durin the congress, called by the Council on Medica Education and Hospitals of the AMA, and arrange ments were made whereby information concernin foreign medical schools received by the AMA, th State Department, the U. S. Office of Education an the New York State Board of Examiners would b pooled in an effort to keep all groups abreast o developments in medical education abroad.

Dr. Terhune to Speak at International Congress

Dr. William B. Terhune of New Canaan has bee appointed by the American Psychiatric Associatio to discuss individual psychotherapy at the Inter national Congress in Mental Health to be held i London August 11-21, 1948. The meeting, whiel is considered of great importance, will mobilize th efforts of professional groups from many countrie for the study and application of the principles essen tial to the building of harmonious human relations This gathering of psychiatrists, psychologists, an other social scientists from all parts of the world i to be the first phase of a new program of worl planning for mental health.

Metropolitan Reduces Premium Rates For Radiologists

Effective January 1, 1948, the Metropolitan Lif Insurance Company reduced its rates for acciden insurance for radiologists, making them the same a for other physicians. This move resulted from th Company's findings based on its accident experienc that "physicians practicing radiology do not offe any greater risk for accident insurance than physi cians in general."

THE PRESIDENT'S PAGE

The most recent attempt to extend federal control of medical care is in the direction of state aid (and thereby control) of school health services. Senate Bill 1290 sets out to furnish to all school children not only preventive and diagnostic but curative medical care.

There is a strong sentimental appeal to such a movement to supply medical care for children who on examination by school physicians are found to have defects. Even where the family and the community are not derelict in meeting this need, it is proposed to supply these services through the schools out of tax funds.

Physicians as a group believe that medical care cannot be furnished extensively by the school system without doing damage to the habits of independence, and the moral fiber of the whole community. Schools must not take from the family primary responsibility for the care of the health of the children. It is like the obligation to give food, clothing, instruction in good manners, in ethics and religion. The schools can help in all of these things but they never can carry the primary responsibility.

Parent-teachers associations often are influenced by this sort of appeal to apply mass methods in the correction of social ills. The Woman's Auxiliary to our State Medical Society, through its members who are our wives and the mothers of our children, can speak effectively on behalf of sound measures. As members themselves of parent-teachers associations they can oppose any movement which tends to develop dependency on the State.

Members of this Society should furnish encouragement to the Woman's Auxiliary in its efforts to promote the influence of the medical profession. It has been well said that one should never underestimate the power of a woman. This is a logical field for extension of our public relations program where it will be effective.

James R. Miller

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

JAMES G. BURCH
Public Relations

258 CHURCH STREET, NEW HAVEN
Telephones: 5-0249, 5-0836

CALL

ANNUAL MEETING HOUSE OF DELEGATES

The 1948 Annual Meeting of the House of Delegates will be held at the Hotel Stratfield Bridgeport, on Tuesday, April 27, beginning at ten o'clock in the morning.

James R. Miller, President
Creighton Barker, Secretary

Council Meeting

The regular monthly meeting of the Council was called to order at four o'clock in the afternoon of March 4, 1948 at the offices of the Society. There were present: Dr. Murdock, Chairman; Drs. Burlingame, Gibson, Gildersleeve, Harvey, Howard, Miller, Parmelee, Phillips, Speight, Thoms, Weld, Barker and Miss Mooney. Absent: Drs. LaMoure, Weed.

AMENDMENT TO BY-LAWS

It was voted to recommend to the House of Delegates at the Annual Meeting, April 27, the following amendments to the By-Laws of the Society:

Committee on Clinical Congress: The Council recommends that Article X, Section 3, Paragraph 2, be deleted in its entirety and that the following be substituted therefor:

Par. 2. The Council shall nominate to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purposes of the committee shall be to plan and make available programs of postgraduate education in medicine, to arrange and conduct the annual Clinical Congress of the Society, and to cooperate with university and other agencies for the extension of postgraduate education of physicians.

THE BUILDING FUND

A report from the Trustees of the Building Fund was read and discussed at length. The report stated:

1. Total amount of cash on deposit in the Building Fund $57,505.

2. Outstanding unpaid pledges $6,213.

3. The property at the corner of Edwards and St. Ronan Streets is owned by the Society without encumbrances (cost $12,000).

COMMITTEE ON MILITARY HISTORY

It was voted to discontinue the Committee on Military History and that the preparation of the projected history be delegated to the Editors of the JOURNAL and the Executive Secretary's Office.

STUDENT MEMBERS

Eleven student members were elected and a list of them is published herewith.

Thomas K. Burnap, New Canaan
University of Southern California
Los Angeles, California—Class of 1948
Pre-med: Dartmouth College
Parent: Clement F. Burnap

Ronald E. Coe, Durham
Tufts College Medical School, Boston—Class of 1951
Pre-med: Colby College, Waterville, Maine
Parent: (not given)

Herbert M. Epstein, New Haven
Univ. of Rochester School of Medicine—Class of 1949
Pre-med: Yale University
Parent: Charles Epstein

David D. Giardina, New Haven
New York Medical College, New York City—Class of 1950
Pre-med: Columbia College
Parent: Vincenzo Giardina

Edward O. Goodrich, Jr., Ansonia
New York Medical College, New York City—Class of 1949

e-med: Yale University
rent: Edward O. Goodrich
ancis E. Korn, Jr., Durham
ew York Medical College, New York City—Class of 1950
e-med: Wesleyan University, Middletown
rent: Francis E. Korn
igi Mastroianni, Jr., New Haven
ston University School of Medicine, Boston—Class of 1950
e-med: Yale University
rent: Dr. Luigi Mastroianni
obert V. Siliciano, Bristol
niv. of Rochester School of Medicine—Class of 1951
e-med: Princeton University
rent: Dr. Raoul A. Siliciano
seph G. Stella, Oakville
emple University School of Medicine—Class of 1950
e-med: University of Connecticut
rent: Henry Stella
harles R. Tourtellotte, North Grosvenordale
niversity of Southern California—Class of 1948
e-med: Dartmouth College
rent: Frank O. Tourtellotte
Villiam F. Zelechosky, New Haven
emple University School of Medicine—Class of 1951
e-med: Univ. of Connecticut
rent: Thomas F. Zelechosky

ONFERENCE OF PRESIDENTS AND MEDICAL SOCIETIES

It was voted that the Society's contribution of 50 to the Conference of Presidents and Other Officers of State Medical Associations be paid.

URSES' ADVISORY COMMITTEE

Dr. Alan Foord was named to succeed Dr. Hartwell G. Thompson as a member of the Advisory Committee to the Board of Examiners in Nursing. Dr. Thompson asked to be replaced on this Committee.

ECTION ON UROLOGY

A request for authorization to organize a Section n Urology in this Society was approved.

SSOCIATE MEMBER ELECTED

Dr. Charles W. Crankshaw, South Windsor, was lected an associate member of this Society. Dr. Chankshaw graduated from the University of Pennsylvania Medical School in 1894 and after an ctive career in medicine in New Jersey, he retired o Connecticut in 1937. He is a Diplomate of the American Board in Internal Medicine, a Fellow of he American College of Physicians, a member of he American Clinical and Climatological Association and a Fellow of the American Public Health Association. Dr. Crankshaw is not licensed to practice medicine in Connecticut.

CALAMITOUS STATE AID PLAN

On request of Dr. Burlingame, the "Calamitous State Aid Plan" was discussed. Information was requested on the subject and the Chairman of the Council appointed Dr. Burlingame, Dr. Miller and Dr. Weld to a special committee to inquire into the subject and report at the next meeting of the Council.

CONNECTICUT NUTRITION COUNCIL

It was voted that the Society become a Class 1 group member of the Connecticut Nutrition Council and the annual dues of $5 be paid.

The meeting adjourned at 6:30 P. M.

SECTION ON UROLOGY

The Council approved a request for authorization to organize a Section on Urology in the Society. This request had been received from Thomas N. Hepburn, Hartford, Clyde L. Deming, New Haven, Bernard Spillane, Hartford, Chris H. Neuswanger, Waterbury, Charles E. Jacobson, Hartford, Robert R. Berneike, New Haven, Charles Mirabile, Hartford, Jacob B. Sigal, Hartford, Harold S. Backus, Hartford, Philip M. Cornwell, Hartford, David W. Byrne, Hartford, H. J. Stettbacher, Waterbury.

The organization meeting of this new Section will be held on Wednesday, April 28, at the Roger Ludlowe High School, Fairfield, during the Annual Meeting of the State Society. Thomas N. Hepburn will serve as temporary chairman. All members of the Society interested in the practice of urology are invited to attend this organization meeting.

Meetings Held During March

Wednesday, March 3, 4:30 P. M.
Program Committee

Friday, March 5, 4:00 P. M.
Council of the Society

Monday, March 8, 5:00 P. M.
Committee on Cooperation with Yale School of Medicine

Tuesday, March 9, 10:00 A. M.
Written examinations of the Connecticut Medical examining Board, State Capitol, Hartford

Wednesday, March 10, 9:00 A. M.
Written examinations of the Connecticut Medical examining Board, State Capitol, Hartford

4:00 P. M.
Committee on Tumor Study, Brady Memorial Laboratory, New Haven

Wednesday, March 17, 4:00 P. M.
Committee to Study Maternal Mortality and Morbidity

Thursday, March 18, 4:00 P. M.
Conference of State and County Officers, New Haven Medical Association

Tuesday, March 23
Executive Meeting, Connecticut Medical Examining Board

New London County Entertains

The New London County Medical Association continued the custom initiated last year by inviting the officers of the State Medical Society to a special meeting on March 4. The Mohican Hotel in New London served an excellent dinner and President Al Labensky did the honors as master of ceremonies. New London County turned out in good numbers and by their friendliness and hospitality showed their approval of the visiting firemen.

At the head of the entourage from the State Society was James R. Miller of Hartford, president. He reviewed developments in our own plans for prepaid medical care, gave his audiences glimpses of the national problems as they concerned the Board of Trustees of the AMA, and touched on the present conflict between the labor government and the medical profession in England. Thomas I Murdock, chairman of the Council, reviewed th more recent developments in the State Society, th work of the Council, the proposed Society buildin and the increasing demands on the State Societ with the necessity for more funds if the Society i to meet its opportunities. Dr. Murdock also told o the developments in the AMA Committee on th Nursing Problem of which he is chairman.

Cole B. Gibson of Meriden, treasurer, Creighto Barker of New Haven, secretary, and Stanley E Weld of Hartford, editor of the JOURNAL, outline to the New London Association members develop ments in their own fields. Dr. Barker's address mus have turned the eyes of each within to see wha manner of physician he was, what he was contribu ting in this complex society in the name of medicine

It was a worthwhile evening. There was no feel ing of haste because of other business to come. Th evening was given over to the State Society officer who were on hand to inform and advise. The New London County Association has evidenced a keer interest in the problems of organized medicine an has set the example for the other seven counties three of them having a much greater membership

American Academy of General Practice

A meeting was held at the home of Julius H Grower, Middletown, on February 19. Severa representatives of the AAGP of the state were pres ent and a petition signed to obtain a charter for a state chapter of the AAGP.

On March 3 this charter was granted and a meet ing was held in New Haven where all members of the AAGP were asked to attend. This meeting was called for the purpose of electing officers for the state chapter.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, JANUARY 10-MARCH 10

NEW HAVEN COUNTY

Allen, John C., New Haven
Celentano, L. E., New Haven
Duffy, William C., New Haven
Giuffrida, Francis, Meriden
Milici, John J., New Haven
Newman, Harry R., New Haven
Rentsch, Samuel B., Derby
Robb, Samuel A., Meriden
Salter, William T., New Haven

NEW HAVEN COUNTY—*Cont.*

Staneslow, John S., Waterbury
Swift, William E., New Haven
Treat, William H., Derby
Zaff, Fred, New Haven

FAIRFIELD COUNTY

Carter, Gray, Greenwich
Mandl, George, Bethel
McMahon, Frank C., Stamford
Patterson, Fred A. Norwalk

HARTFORD COUNTY

Butler, Nicholas G., Hartford
Case-Downer, Muriel, Hartford
Hennessy, James J., Hartford
Mlynarski, Joseph A., New Britain
Winters, John T., Hartford

NEW LONDON COUNTY

Hanaghan, James A., Norwich
Sabloff, Jack, Manchester

THE HARTFORD HOSPITAL MEDICAL CENTER



ON Sunday afternoon, March 14, the new $8,000,000 building of the Hartford Hospital was dedicated. The ground was broken for this new building 9 days after V-J day and, in spite of shortages of materials and labor problems, construction has continued apace until now it is completed and ready to receive patients. This building is 14 stories high and features many step-saving devices which it is hoped will aid in offsetting the manpower shortages, especially those in the nursing departments. These devices include two vertical conveyor systems installed for the first time in a hospital building. Goods and articles are put in large fibre baskets and carried from floor to floor. Over four miles of pneumatic tubing goes to every department to make possible the sending of medical records and material. A call system operates between every patient's bed and nurse's station and between the station and the kitchen, service room, etc.

The hospital in the new building will have 978 beds, a total of 122 more adult beds than in the old building. This includes the maternity beds and 168 bassinets in the South Building which was erected in 1941-1942. It does not include Avery Convalescent Hospital. One of the new features is the neuropsychiatric floor with 90 beds and an isolation floor with 9 beds, both designed to care for cases coming within these categories and developing among patients already within the hospital. The largest rooms in the new hospital will contain but 4 beds and nearly all floor units will have 27 beds. The hospital also has an amphitheatre seating 151 persons, to be used for teaching purposes. Balconies in 4 of the 16 operating rooms and in the local anesthesia room will enable students and visiting physicians to observe without entering the rooms.

Wilmar M. Allen, M.D., director of the Hartford Hospital, gave the dedication address to a gathering of about 500 friends. Mr. William H. Putnam, president of the hospital, was master of ceremonies. Those taking part in the presentation and acceptance of the key were David P. Appell, vice-president of the George A. Fuller Co., contractors; Henry R. Shepley of Coolidge, Shepley, Bulfinch and Abbott, architects; Norman B. Bertolette, chairman of the building committee; and H. Gildersleeve Jarvis, M.D., chairman of the building committee of the staff. The Reverend Sidney W. Wallace, Canon of Christ Church Cathedral, pronounced the benediction.

Just 10 days prior to the dedication of the new Hartford Hospital building, ground was broken for a new 8 story structure designed to accommodate 90 physicians' offices. This new office building will adjoin the new hospital on the north and will cost about $1,500,000 to construct. It will be erected by the Connecticut Mutual Life Insurance Company on property sold to the insurance firm by the hospital.

The first floor of the new office building will contain several shops, including a pharmacist, a florist, and a barber, and such other shops as may be deemed advisable for the convenience of tenants,

patients and visitors. An L-shaped plan has been evolved by the architects, Moore and Salisbury, providing elevators and services at the center and corridors running at right angles to each other.

The main entrance will be protected by a marquee faced with stainless steel, and the first level will have a continuous hood over display windows and stone piers. The materials to be used for the new building will be in harmony with those used in the hospital building. The walls will be of white "vitri-granite" brick.

The building will be equipped with a system of forced ventilation, introducing fresh air into the main corridor on each floor, and all interior rooms and spaces will be mechanically exhausted by ducts through the roof. Heating will be provided through inconspicuous flush copper convectors, concealed under windows and supplied by a zoned system from steam piped from the hospital's power plant. Gas will be available in the corridor ceiling of each floor, and light and power outlets will be located to suit tenants.

All interior columns will serve as pipe and ven shafts, making it possible to install plumbing fixture wherever necessary. Sound control, as well as acces sibility of pipes and conduits, will be afforded by demountable perforated metal pan and minera wool ceiling throughout.

The Medical Building will contain a laboratory managed as a private enterprise but which will be closely affiliated with the hospital pathological department.

By its close proximity to the hospital this new medical building should mean the saving of consid erable time to the 90 members of the satff who will rent the new offices. The committee of the staff who planned this project with the insurance company comprised Thacher W. Worthen, chairman; Charles S. Mirabile, secretary; Philip J. McLellan, Louis F. Middlebrook, and Benjamin V. White. The 8-story building will be directly connected with the new hospital through the first 4 floors. Construction is anticipated to require about 1 year for completion.

RADIO, PRESS AND MEDICINE CONFER IN BOSTON

THERE was one question the Council of the New England State Medical Societies did not answer at its conference in Boston on March 7. That was "why will not the physician submit more accounts of his achievements in the field of medicine to the radio and the press for the information of the public?" It is the old question of advertising which the New England doctor has been brought up to believe is unethical. This point of view may experience a change some day, but only after a new generation of physicians has been raised who will change its code of ethics and find it right and proper to inform the public of scientific achievemnts in every day practice.

The subject of the conference was "The New England Doctor and His Public." Arthur H. Ruggles, president of the Rhode Island Medical Society, presented the speakers. Representing radio was James S. Powers of Boston, director of the Yankee Network Institute under whose guidance the broadcasts, "Doctor's Orders," have been given to the public each Sunday afternoon. Mr. Powers related how Boston has been placed in the front rank of adult education in the United States by its series of medical broadcasts. He has had requests for use of the script from South America and from New Zealand. The Yankee Network, because of these broadcasts has received the Massachusetts Peabody Award and has been invited to submit presentations for a national award.

Dr. John F. Conlin, director of medical information and education of the Massachusetts Medical Society, discussed the radio from the physician's point of view. He reminded his audience that there is today a consumer demand for good health information, that the physician is often misquoted by so-called science reporters, and that it is necessary to transmit medical information to the public with forcefulness and in the terms of the layman.

The city editor of the *Hartford Courant*, Maurice Cronan, raised the question of the barrier between the press and the physician brought about by the repeated necessity of explaining fundamental terms to the average reporter. It was this newspaper man who admitted that the press was poorly organized to meet medicine for the purpose of straightening

t their common difficulties. Mr. Cronan also ised the $64 question of the lack of willingness of e physician to report his personal scientific hievements. "When caring for an important indidual," said Mr. Cronan, "leave a report for the ess with the information desk at the hospital, or her responsible person. This will keep you from ing disturbed at inconvenient hours." Mr. Cronan so requested that a synopsis of scientific papers to delivered before the medical societies be subitted to the press. His remarks about the public lations, or lack of such, of some of our hospitals ere critical.

The viewpoint of the smaller city newspaper was ly presented by Gerald E. McLaughlin, managing litor of the Rutland (Vt.) *Daily Herald* and chairan of the New England Associated Press in 1946. Ir. McLaughlin told the conference the unwillingess of physicians to cooperate with the press in overing sources of news was due to lack of underanding. "The medical society," said Mr. McLaughlin, "should be a liaison bureau between the hysician and the press." Also he urged that more hysicians accept the opportunity to speak before vic organizations.

The two papers by the representatives of the press ere ably discussed by James G. Burch, director of ublic relations of the Connecticut State Medical ociety. One of his opening remarks was, "What the function of the newspaper in society today?" Ir. Burch stressed the importance of medical news the public and reiterated the statement of Mr. onlin, that there is a public demand for such news.

"The Doctor's Role in Community Programs" as the subject of a discussion by Hugh R. Leavell, rofessor and head of the department of public ealth, Harvard University School of Public Health. Dr. Leavell emphasized three points: (1) he physician must know what constitutes an adeuate health program; (2) he must participate in uch a program as an individual citizen; and (3) the hysician's wife must carry her share of the burden. The discussant for Dr. Leavell was Robert O. Blood, M.D., former Governor of the State of New Hampshire. Dr. Blood spoke from several years of ersonal experience when he said, "No one else is ualified to lead in public health community work ut the physician."

Representatives were present from all six New ngland State Medical Societies including Charles . Kickham, vice-president of the Massachusetts Medical Society, who welcomed the conference in the absence of President Bagg. Those attending from Connecticut were: Creighton Barker, Cole B. Gibson, Joseph H. Howard, James R. Miller, Grace Mooney, Harold E. Speight, and Stanley B. Weld.

Peripateticus

Dr. Gray Honored

Dr. Albert S. Gray, director of the Bureau of Industrial Hygiene, Connecticut State Department of Health, was presented with the distinguished service award of the Connecticut Safety Society during its third annual Industrial Safety Conference held recently in Bridgeport.

The presentation was made by LeRoy J. McCarty, safety supervisor of the Remington Arms Company, who commended Dr. Gray as "a true pioneer in occupational disease prevention." In accepting the award, Dr. Gray praised the loyalty and accomplishments of his staff.

Addressing a meeting of industrial nurses which featured the afternoon program John N. Gallivan, medical director of the United Aircraft Corporation, declared that a number of industries are now showing marked interest in disabilities of workers which are not directly connected with their employment. This interest he portrayed as a new threshold in the industrial health and safety movement, and one in which industrial nurses will continue to play a leading part.

"In order to keep pace with the newer opportunities which industry is presenting, the general trend in industrial medicine is toward the solidification of specialties such as nursing, safety engineering, and industrial hygiene," he declared.

Especially important in the future progress of industrial health will be the nurses in smaller industries, Dr. Gallivan said, and emphasized that progress in this field will depend upon individual effort.

The Honorable Jasper McLevy, mayor of Bridgeport, welcomed the more than 300 delegates from Connecticut industries in attendance at the conference. Guest speakers included Donald F. Carpenter, vice-president and assistant general manager of the Remington Arms Company; H. W. Heinrich, assistant superintendent, engineering and inspection division, Travelers Insurance Company; Robert Clair, director of safety education, Liberty Mutual Insurance Company; T. O. Armstrong, director of plant labor relations, Westinghouse Electric Cor-

poration; Walter A. Cutter, Center of Safety Education, New York University; and Ralph J. Crosby, manager, safety engineering department, Marsh and McLennan, Inc., New York City.

Dr. Lundborg Receives Croix de Guerre

In April 1947 Francis L. Lundborg of West Hartford was the recipient of an official document from the French Minister of War bestowing upon him the Croix de Guerre. The citation grants authority for the acceptance and wearing of this award and for the appropriate entry in personnel records. The decoration consists of a ribbon and a silver star.

The citation follows:

DECISION No. 154
Le Ministre de la Guerre A. DIETHELM
cite
a l'ordre de la Division
le Capitaine Francis L. Lundborg
265th Medical Detachment
"pour services exceptionnels rendus au cours des operations de la liberation de la France"
Cette citation comporte l'attribution
de la Croix de Guerre avec etoile d'argent
Fait a Paris, le 25 Octobre 1945
Signe: DIETHELM

Pour ampliation:
Le Chef de Bataillon LEMOINE
Chef de la Section Decorations

Dr. Winternitz Receives Award

Milton C. Winternitz of the School of Medicine at Yale University was listed among Americans who received awards from the British Empire for contributions to the Allied war effort in various fields of scientific research and development.

Dr. Winternitz, who is engaged in research at the laboratory of pathology at the medical school, was made an honorary officer of the civil division of the Most Excellent Order of the British Empire.

The awards were announced by British Ambassador Lord Inverchapel who named a group of Americans awarded the same honor as Dr. Winternitz, and another group who were made Honorary Commanders of the same order.

Dr. Vannevar Bush, director of the Office of Scientific Research and Development, was m Knight Commander of the order.

Health Insurance Debated

"Is a National Health Insurance Plan Necess in the United States?" was the subject of a p discussion held at a recent meeting of the Hartf Get-Together Club at the Hotel Bond.

Principal discussants for the program were Jos H. Howard, past president of the State Med Society, and chairman of the Connecticut Comm sion on the Chronically Ill, Aged, and Infirm; Bernard S. Meyer, chairman of the New Y County Chapter of the Physician's Forum. Kimberly Cheney, president of the club, presided

United Medical Service Increases Benef

United Medical Service, sponsored by the Me cal Society of the State of New York and 17 cou medical societies, after 3½ years of experience announced an increase in its benefits to enrol members. New surgical and surgical-medical p contracts became effective January 1, 1948. Bene granted members of UMS on a temporary ba have become a continuing feature under the n contracts. In addition the amount paid to physici for normal obstetrical delivery on behalf of UM members enrolled in the surgical plan has be increased from $60 to $75.

Persons enrolled in the surgical plan, which cov maternity care in the hospital and surgical care the hospital or doctor's office, including the tre ment of fractures and dislocations, now are al assured of maximum payments up to $225 towar physician's fees as against the former maximum $150.

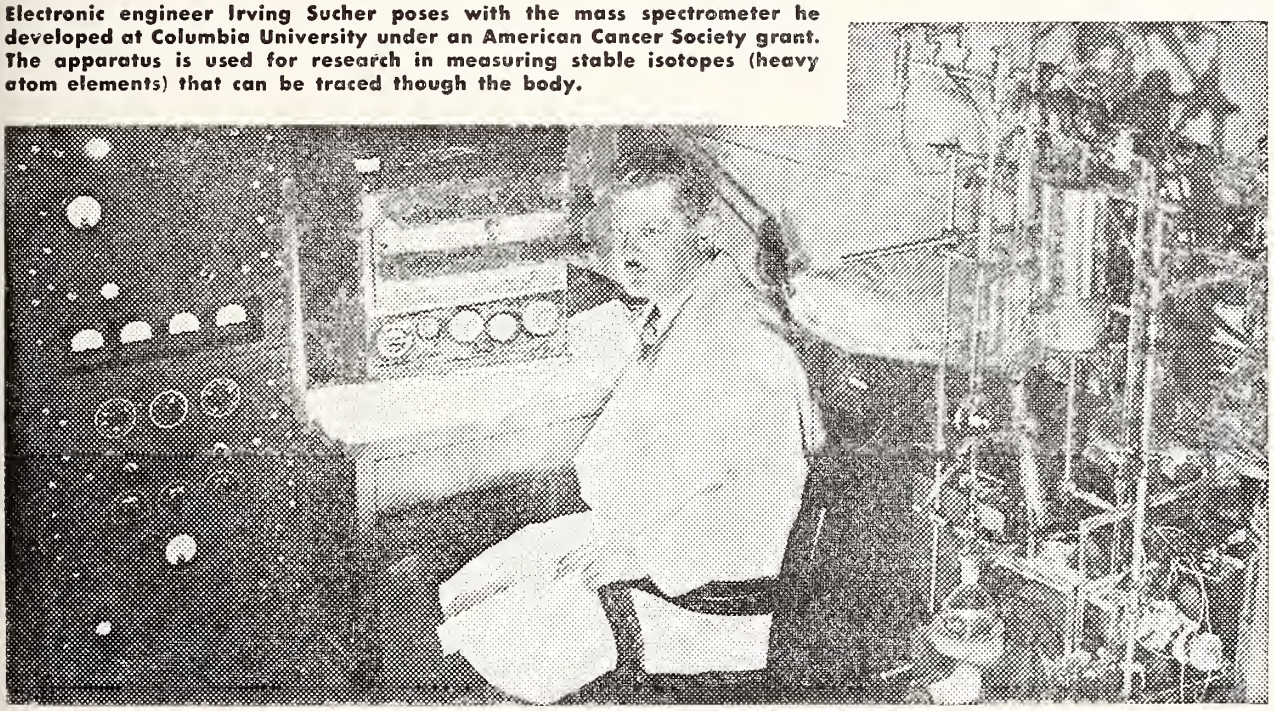
Another former "dividend," now included in t UMS surgical-medical plan contract, entitles me bers to specified payments for medical care in t hospital beginning with the first day of admissi instead of the fourth day. The maximum paymen for each hospital admission comprise $200.50 against a former maximum of $182.50.

As of February 1, 1948 United Medical Servi has an enrolled membership of 710,000 and 13,9 participating physicians.

CONNECTICUT CANCER SOCIETY

NEW ISOTOPE TRACER TO AID CANCER RESEARCH

Electronic engineer Irving Sucher poses with the mass spectrometer he developed at Columbia University under an American Cancer Society grant. The apparatus is used for research in measuring stable isotopes (heavy atom elements) that can be traced though the body.



Hartford Pre-Campaign Dinner

bout 250 workers in the coming Cancer Society paign gathered at the Hartford Club on Febru- 19. The first part of the after-dinner program, uding speeches by Governor McConaughy and sident Jorgensen of the University of Connecti- was broadcasted to the public. The national l of $16 million was emphasized and the appor- ment to research, education, and the diagnosis treatment of cancer clearly outlined. Harry A. rphy, national campaign director, called atten- to the fact that the American Cancer Society now made 500 grants and fellowships to colleges universities for the study of cancer.

rather a long drawn out round of speeches, e relief from the discomfort of the ball room irs was afforded by Benedict J. Duffy, assistant ctor of the Service Division of the American cer Society. Dr. Duffy reviewed the progress le by the medical profession in combating can- since the discovery of the disease. He then hasized the fact that, notwithstanding the clinics and the refinements in diagnosis, the general practitioner is the key to cancer control.

Harry F. Morse of New London, chairman of the State campaign committee, acted as toastmaster. The State Chairman of the 1948 Campaign, Richard H. Valentine of Stafford Springs, encouraged the workers with a realization that ballyhoo was not needed to put over the drive, and Creighton Barker, State president, wished them all "God speed" in their efforts.

The State goal in the 1948 campaign is $347,440 of which $75,425 is to be raised by a Hartford district committee headed by Charles H. Walters. The campaign will be conducted in April.

The Cancer Drive Is On

So far in the battle between Cancer and Man, Cancer has held the upper hand—has been on the winning side.

In 1937, there were 144,774 cancer deaths recorded in the United States. In 1945, the number of Americans reported as fatal victims of the disease

jumped to 177,464. At the rate cancer is "waging war," the estimated death toll for 1948 is expected to be approximately 195,500.

At the rate it is striking persons of all ages, 1,400 of this estimated number for 1948 will be children; 93,800 will be men and 100,300 will be women.

Our own home town, like very other community, will get its share—and the yearly price in human lives will be bigger each year—*unless the forces now at work start turning the battle the other way.*

Yes, a fight to turn back cancer is being waged—on every front that medical, scientific and lay leaders can open.

Through the American Cancer Society, Cancer Research is being carried on in 70 American institutions, located in 24 states.

In our own state, through the Connecticut Cancer Society, an official division of the American Cancer Society, 14 Cancer Information Centers have been established, where help and information is available without charge. Four Detection Centers have been opened, where thorough physical examinations, checking for cancer are available to the public.

A huge educational program is at work. Nursing help to cancer sufferers has been intensified. Scores of volunteer cancer control groups are doing all they can in communities all over the state.

To help Connecticut achieve its quota of $347,440 is not just an act of charity. It's an *investment* in the Research, Education and Service work that are our only hope against this killer.

April is give-to-conquer-cancer-month . . . give all you can!

The Controversy In England

Among other releases from overseas bearing on the present conflict between the British Minister of Health and the medical profession has come one from a layman by the name of Colm Brogan.* It is a very strong statement in defense of the British physician. The following quotation is taken from this article entitled "The Day of Decision."

"It has fallen to the doctors to meet and break the authoritarian demand. They have not asked for this responsibility and they have not welcomed it, but the layman may well be thankful that it is the doctors who have been called upon to fight liberty's Battle of the Marne, because they have all the me of conclusive victory, if they have the will. more depends on this than the future of med practice. The future of personal liberty is in balance. The doctors can strike a blow that will only free themselves but will give hope of freed to us all.

"That is why the plebiscite is a matter of gravest national concern. Our liberties are still lar but they are contracting, and an evil idea is gain dominance. Now is the time to reject and refute idea. Doctors have not sought this fight, but th cannot now avoid it, and they have the decis weapon in their hands. Let them strike home for of us.

"It may be that doctors feel the public has sho little sympathy and understanding, but they ha one infallible means of enlisting sympathy and p voking interest—throw out the scheme. The pub will conclude, and rightly conclude, that the dc tors must have a solid case because they gave a so vote. The vote will rouse a general and start interest, and the issue of private conscience agai public policy will be clear for all to see."

*British Med. Jour. Jan. 31, 1948.

Army Gives Basic Science Course

To meet postwar conditions and insure its p sonnel the best in medical care, the Army has tak a long lead in progressive medical education at t postgraduate level. An important part of the n trainnig program is the Basic Science Course n being given to a group of picked "students" (Arı doctors ranging from captains to full colonels) the Army Medical Department Research and Gra uate School at Washington. The course makes u of actual patients as the starting point for discussi of fundamental concepts in the fields of chemist physics, anatomy, biology, pharmacology and t other basic sciences as they relate to medical dia nosis and therapy. The 16-week course represe an entirely new concept in medical education, a has already proved its worth to such an extent th several university medical schools are using it as model in the reorganization of their advanc courses. Plans are being made to give the cou once a year.

C. N. H. Long, dean of Yale University Medi School, covered the subject of carbohydrate meta olism in this course. John K. Peters, professor medicine at Yale, introduced the subject of wa metabolism.

OMMITTEE ON PUBLIC POLICY AND LEGISLATION
eld County, Charles H. Sprague, Bridgeport
ord County, Benjamin B. Robbins, Bristol
field County, W. Bradford Walker, Cornwall
lesex County, Richard H. Grant, Cromwell
London County, Edmund L. Douglass, *Chairman*
oton
Haven County, Charles T. Flynn, New Haven
nd County, Leonard W. Levine, Ellington
lham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

THE NURSING PROBLEM, EDUCATIONAL ASPECT

THOMAS P. MURDOCK, M.D., *Meriden*

The Author. *Member A.M.A. Committee on Study of Nursing Service in America*

THE NURSING problem, particularly that phase having to do with the shortage of nurses, is ably the most serious matter confronting erican medicine today. Hospital authorities have complaining of their inability to adequately their institutions. Doctors have maintained that usly ill patients were being denied badly needed ing care. Nurses are insistent that they have carrying an enormous burden due to the tage.

hat the seriousness of the situation is appreciated can readily see by the actions taken by several nal medical organizations including the Ameri- Surgical Society, the American College of Sur- s, the American College of Physicians and the erican Medical Association. All of these organi- ns have appointed committees to study the blem.

nursing structure study is being conducted by Esther L. Brown for the National Nursing ncil on a grant from the Carnegie Foundation. ause of her background and training and expe- ce it is expected that her study will be compre- sive and her report awaited with great interest.

ll interested agree that there has been and is a tage. There is some disagreement as to the ree and cause of the shortage and methods of rection. A recent survey by the American Hos- l Association seems to indicate some relief. lying to a questionnaire 2,300 hospitals answered of this number 37 per cent replied that if more nurses were available they would not need to engage them. We hope that when our study is completed all of these questions will be fully and finally answered.

"Facts About Nursing 1947" shows some very unusual and interesting figures. In 1940 there were 371,066 graduates and students in training. In 1910 there were 82,327. Of the number in 1940—97.7 per cent were females and 2.3 per cent were males. And of this number there were 7,065 female negro nurses and 127 males.

"Facts About Nursing 1946" also provides some very interesting and unusual figures. The number in active practice 317,800. The number admitted to training schools in 1940—38,000. In 1942—47,500. In 1943—53,074. In 1944—67,051. In 1945—57,000. In 1946—30,899. From these figures you will notice the large increase in numbers admitted to training schools from 1942 and including 1945. This, of course, is explained by the Cadet Nurse Corps program. Were the increases due to patriotism, glamour of the uniform, the stipend? The answer to the whole problem is probably in these figures.

The demand for nurses increases by leaps and bounds. In 1910 there was one nurse per 1116 people. In 1946 there was one nurse per 316 people. One million more patients were admitted to hospitals in the U. S. in 1946 than were admitted in 1945. Prepayment hospital and medical plans have and will have much to do with this problem. As the plans increase in number and subscribers, the demand for hospital staff nurses and private duty nurse will increase and will have to be provided.

A report recently released by the Women's Bureau of the U. S. Department of Labor is stagger-

ented at the 21st Annual Meeting, National Council on Medical Service, Chicago, February 8, 1948

ing. The release estimates that the number of nurses needed in 1960 will be 500,000 to 550,000. This is based on an estimated population in 1960 of 153,375,000. It is described "as a realistic appraisal of possible attainment rather than an estimate of what ideally is desirable." To obtain what they describe as "ideally desirable" would require twice this number. As the result of the cadet corps training 44,700 nurses were graduated in 1947. This was the largest class graduated. This standard will have to be maintained during the period 1951-1960 if the estimated needed result is attained. These figures may be fantastic. I hope they are.

The economic studies present some interesting conditions. It is difficult to work out an average salary paid nurses in the United States. In 1946 it was estimated that the average income of the nurse was $170 to $175 a month. In 1947 one estimate placed it at $185 a month. Another between $175 and $180. In general the average week is forty-four hours. Social security is not provided. Only a few hospitals have provided retirement plans. The American Hospital Association has worked out a retirement plan. Only a small percentage of nurses have taken advantage of this and only a few hospitals carry it.

One could ask why the shortage of nurses? There would be many answers and included in these would be (1) the general woman power shortage due to the competition of business in the labor market; (2) Relatively small pay and long hours of work; (3) Poor living conditions and lack of provision for recreation in training schools; (4) Lack of retirement funds; (5) Not being covered by social security; (6) The nurses describe a hard medical and nursing hierarchy.

I think we can all accept the first and second premises with the women power shortage and small pay. These young ladies actually take graduate work that in time, at least, is comparable to college training and are then required to work for a salary that could easily be obtained in other lines of work and without the added three years of training.

In many hospitals the living conditions of nurses are poor. Dormitories are crowded. Little or no provision is made for recreation. This is due to lack of funds or short sightedness on the part of boards of directors.

Retirement funds and social security must be provided. This is not said from a moral viewpoint. On the contrary, these must be provided if hospitals and other health agencies are to compete w industry and business in general.

The files of the committee contain a great ma letters from nurses severely condemning what general they call the hard medical and nursi hierarchy. The nurses, in these letters, state t doctors have been unfair and unjust in their cr cisms. Using their own phraseology they say t doctors have "lorded it over them." They are a critical of hospital administrators and nursing ec cators because of their dictatorial attitudes. T should be and probably can be corrected.

What is to be done about all this? It is a big a difficult problem. It concerns us all personally a more than that it concerns American Medici greatly. There are those who would use this sitt tion as an indication of the need of compulso medical and nursing care. This is not so and I de it vehemently. It insults one's intelligence to be t that governmental interference, and I use the phr advisedly, would provide more or better nurses a more than it would provide more or better docto

I would like to say at this time, that the nur are as anxious as any group to have this probl solved. They have been most cooperative and he ful to the committee.

The committee will make its final report to t House of Delegates at the annual meeting in Ju The study is nearing completion. It would be i proper for me at this time to present it here ev as far as we have gone. The report belongs prope to the House of Delegates. When it is in I hope will please you.

I can tell you that a permanent conference co mittee has been formed. This committee is made of representatives of the nursing profession, t American Hospital Association and the Americ Medical Association. The Board of Trustees h appointed a commitee to represent the Americ Medical Association. This conference committ has already begun to function and will attempt solve problems common to all. The committee co tinues its studies along the lines: of (1) Immedi relief; (2) Future planning for training of bedsi nurses and nursing educators; (3) Economic studi

The American Medical Association intends t this problem will be solved, and more, that nev again will America find itself in this position.

The President, Dr. E. L. Bortz, has stated t all of the resources of the American Medical As

tion are behind this study. The Board of Trustees a l the Chairman, Dr. Elmer Henderson, have given committee complete support. The editor of the *rnal*, Dr. Morris Fishbein, has greatly aided the nmittee from his large fund of knowledge of this ject.

The committee asks the help of all the doctors in United States. It asks the endorsement of the tional Conference on Medical Care. It is receiving at aid from editors of a great many state and unty medical journals. Many of the editors have itten several editorials.

This problem is one for nurses, doctors and hos- al executives to solve. It is not the problem of any e group. The nurses are allies and aides to doctors. must and will be solved with the generous co- eration of all. The committee of the American edical Association seeks your aid.

World Health Organization Gets Underway

In the proposed 1949 budget of the World Health rganization, the largest single sum, $1,071,690, is lotted for fellowships, medical literature, teaching uipment, and emergency medical supplies. These ill be used in the field services program to help tional health administrations meet postwar prob- ms with up-to-date scientific knowledge and uipment. Another important sum is provided to lp governments of countries cut off from scien- fic developments by wartime censorship by fur- ishing advisory services and teams to demonstrate w medical and public health techniques. This udget will be acted upon at the first World Health ssembly scheduled for Geneva from June 24 rough July 1948.

Among the major decisions recommended by the fth session of the Interim Commission to the first Vorld Health Assembly and the WHO are the llowing:

(1) Medical cooperation with accredited govern- ental and non governmental agencies should be ontinued. It was recommended, therefore, that the ssembly adopt the draft agreements drawn up by he Interim Commission with several UN Special- zed Agencies. These agreements provide that the VHO shall serve in an advisory capacity in the ields of public health and medicine with the fol- lowing organizations: the International Civil Service Advisory Board, the UN Social Commission, the UN Scientific Conference for the Conservation and Utilization of Resources, ILO, UNESCO, and FAO. Collaboration between WHO, IC and FAO on nutrition projects has already started.

(2) The necessity for revision of existing sanitary conventions, which has long been recognized, came up for debate during the discussion on cholera. Several countries took measures far exceeding the provisions of the international sanitary conventions. A list of these measures will be established and the governments concerned will be asked for an explanation as to the scientific grounds on which such action was based.

(3) In the field of basic studies to develop uniform standards and procedures, the Interim Commission recommended continuation of the work of biological standardization, and unification of pharmacopoeias was recommended as one of the most important WHO projects.

(4) The creation of an international influenza center, which is now well under way, is another project of major importance, since the danger of another influenza pandemic like that of 1918-19 is ever present.

(5) Revision of the international lists of diseases and causes of death, so far undertaken every 10 years under the auspices of the French Government, now becomes the duty of WHO. The Sixth Decennial Revision Conference will be convened in April 1948.

(6) Distribution of radio-active isotopes by the United States is of major interest to WHO, which will appoint an official at its Headquarters Office to act as the designated representative of countries not having a scientific attache in the United States.

(7) The Interim Commission also recommended pressing the campaigns against important communicable diseases and promoting health protection for children.

(8) Malaria, a major factor in the present worldwide food crisis, has been singled out for mass attack according to recommendations in the WHO.IC report. Hundreds of millions of people are reported to suffer yearly from this disease, especially in rural areas. This situation continues despite new discoveries which made it possible to control malaria.

(9) A tuberculosis control program is another top priority item on the list of Interim Commission recommendations.

(10) Venereal diseases will also be attacked on a worldwide scale. The primary emphasis will be put on diagnosis and treatment of early syphilis and large-scale use of the pencillin treatment.

(11) Maternal and child health programs will be launched at the earliest date, according to Interim Commission recommendations. A comprehensive proposal submitted by the U. S. delegation was adopted as a working basis by the Interim Commission. Objectives set forth in the recommendation include not only giving infants the best possible chances of survival and providing to all children normal physical growth and development, but also assuring mental and emotional health. Infant mortality and the social aspects of the program are among the subjects recommended for study, and provision is made for joint undertakings with other agencies.

The Manufacturers On Compulsory Health Insurance

Mr. Edward Ingraham, president of the Manufacturers Association of Connecticut, Inc., discusses compulsory health insurance in the February issue of *Connecticut Industry*. "Rhode Island," writes Mr. Ingraham, "was the first state to adopt a compulsory system of disability compensation." And farther on: "In 1946 California enacted legislation amending its unemployment compensation law to provide cash benefits for unemployment resulting from disability or illness not otherwise compensated for." By the amendment of the Social Security Act by the 79th Congress Mr. Ingraham reminds us that this making available funds for unemployment disability puts pressure for the enactment of a sickness benefit law on Alabama and New Jersey. These are the only states besides Rhode Island and California which require employee contributions to unemployment compensation funds.

Next comes the field of compulsory health insurance. The Manufacturers Association of Connecticut is now conducting a survey to discover the coverage of employees by some form of non occupational sickness or accident protection. The closing paragraph of Mr. Ingraham's article is worthy of consideration.

"With a Workman's Compensation Act in force in Connecticut, which is probably the most liberal in the United States in giving hospital, surgical an medical care, as well as disability benefits to thos injured or made ill as a result of employment i industry, and with constant expansion of privat voluntary programs, the long-run welfare of ou citizens lies in the direction of voluntary localize private plans, or those underwritten by insuranc companies. I strongly believe this because the evi dence in favor of compulsory health and cash-sick ness plans is more than offset by studies of thes plans which reveal the following outstanding weak nesses:

1. The principle of compulsion in health or sick ness insurance by government authority will even tually lead to complete state control in this field.

2. Compulsory insurance programs are based o political interests rather than on social need an public demand.

3. Such plans assume that workers are so improvi dent or so inadequately compensated for their worl that they or their employers must be coerced t provide sickness benefits during periods of dis ability.

4. Once a system which provides cash sicknes benefits is placed on the statute books it inevitably follows that pressure will be exerted to inaugurat government controlled medical care.

5. Compulsory government plans eliminate much of the freedom to choose doctors and reduce the quality of medical care because of "red tape" and lack of incentive which is given to physicians under a system of private medical practice.

6. Encourages absenteeism and malingering.

"Let us work for the greater good of all through improving our voluntary programs while standing firm against the evils that will beset us if we succumb to the high sounding promises of those who advocate either compulsory health insurance o national medical care for all."

Eli Lilly and Company Head Dies

Josiah K. Lilly, chairman of the board of directors of Eli Lilly and Company, died on February 8. He became president of the company on the death of his father, Colonel Eli Lilly, in June 1898. Under his management Eli Lilly and Company became one of the outstanding organizations in the pharmaceutical field, with international distribution. Josiah Lilly himself was the recipient of honorary degrees from eight colleges and universities during his lifetime.

NEWS FROM WASHINGTON

National Health Assembly

At a press conference on February 13, Federal curity Administrator Ewing announced that, imulated by the President's message he is arranging r a National Health Assembly to meet in Washgton, May 1 to 4, at which time a ten-year health rogram will be outlined. He expects an attendance f about 800 delegates and has selected an executive mmittee of 24 national leaders. On this executive mmittee the representatives of medicine are dward L. Bortz, president, R. L. Sensenich, presint-elect, and George F. Lull, secretary and genal manager of the AMA. Mr. Ewing says that hile he is in accord with the President in believing at we should have a national sickness insurance rogram, nevertheles, he believes that there are any activities in the health field that are less conoversial that his Agency could and should be romoting with public support and cooperation.

Among these activities he mentioned medical search, medical education, stream pollution and e creation of Public Health units. He proposes to ve the delegates to the Assembly develop workg programs in these fields. One panel will be signed compulsory health insurance.

In an address delivered before the National Health ouncil in New York on February 17, he discussed greater detail some of the things which he hopes e Convention will carefully consider. In the field medical education, he said that he is convinced at Federal aid to medical schools and medical udents is essential and he proposes that it be stimuted by: (1) grants to medical schools for operating penses; (2) grants for construction of new buildgs and additions to existing buildings; and (3) a holarship program to increase the number of ersons training for medical, dental, nursing, and blic health service, to the nation. To implement e first, he proposes a program of annual grants, proximating $50 million—no grant to exceed 50 r eent of the cost of instruction in the school ring the year.

He named no specific sum for implementing his eond project, but said the size of this part of the rogram might well be left to annual determinations rough appropriation requests. Under the third, or holarship, program he thinks of two types of scholarships: (1) a State scholarship for doctors, nurses, dentists, and public health personnel, who could practice anywhere they wanted to; and (2) a national medical scholarship where doctors agree to serve for a time in special doctor shortage areas.

The first would be State scholarships made possible through grants to each of the States, for a total of 10 per cent of the doctors, dentists, nurses and public health personnel enrolled in such professional schools. The amount of the State scholarship would include tuition, books and fees, but not room and board. The second type would be national medical scholarships, not to exceed $600 annually. These would be available to doctors who agree to serve for some period in Federal medical establishments, such as VA, the Public Health Service, the Army, the Navy, or in State and Local agencies; as, for example, in doctor shortage areas designated by State health authorities. The latter scholarships would cover tuition and would also include $90 a month for living expenses.

The Journal of the American Medical Association states that the National Health Assembly, called by Oscar R. Ewing, federal security administrator, to be held in Washington, D. C., May 1-4, "bears all the stigmas—political and propagandistic—that accompanied the National Health Assembly of 1938." The conference of 1938 was organized with a preponderance of representatives of non medical groups. The non medical speakers were given the major portion of time on the radio, and the publicity, which was in charge of Mr. and Mrs. Ernest Lindley, greatly emphasized the propaganda in behalf of compulsory sickness insurance. The speakers, representative of governmental agencies, were given almost unlimited time and the program, which was announced by Isidor Falk in an address of more than an hour and a half, was the government's program. Actually the government's program had been fully prepared and was presented for the first time at the conference, and no attempts were made to elicit, nor was opportunity given for consideration of, any other program or, indeed, for a detailed discussion of any part of the government's program. In other words, the National Health conference of 1938 was designed as propaganda and participation by the medical profession merely gave it an authenticity that it did not merit.

Since that time the Government agencies involved in this type of propaganda have learned many new tricks. They have lined up proaganda groups outside the Government that are willing to go along with the Federal plans. The pattern is perfectly transparent. Inside the Federal Security Agency there is an equally transparent pattern of action. One can picture now the feverish activity in the Bureau of Research and Statistics of the Social Security Administration, in the Division of Public Health Methods in the Public Health Service, and in the Children's Bureau. Reports of dubious authenticity will be turned out; questionable statistics will be prepared; and recommendations will be drawn up in advance. Since this is all known now, it is possible to change the pattern. One is not compelled to be steam-rollered by power-crazed, ambitious Federal officials. After all, you and other taxpayers are furnishing the funds for these Federal officials. If you disapprove of their activities it is your privilege and duty to protest to them and to the President. But there are constructive things that can be done in addition to voicing criticism. Within the next two months health and medical groups throughout the country could let their voices be heard in every local newspaper, on the air, and at numerous meetings. Prompt action is vitally important.

Dr. Parran Out, Dr. Scheele In

In February President Truman announced the appointment of Leonard A. Scheele, M.D., to succeed Dr. Thomas Parran as Surgeon General, USPHS, on April 6. The Scheele-for-Parran switch may have surprised many physicains but not Dr. Parran. After the retirement of General Kirk and Admiral McIntire and the recent evidence of Federal Security Administrator Ewing's intention of becoming his own Surgeon General, Dr. Parran's reappointment for another four year term was out of the question. He has succeeded in helping to obtain as his successor a man whom he describes as "one of the outstanding public health figures in this country" and who "possesses both personal and professional qualities to be a great Surgeon General."

Dr. Scheele was born in Fort Wayne, Indiana, July 25, 1907. He received his A.B. from the University of Michigan in 1931; his B.S. in Medicine in 1933 and his M.D. in 1934, both from Wayne University, Detroit, Michigan.

He entered the Public Health Service immediately and held several field positions until 1937, when he became a Special Fellow at the Memorial Hospital, New York, for two years. In 1939 he was put in charge of the National Cancer Control Program of the National Cancer Institute until 1942, when he was transferred to Civilian Defense. From 1943 to 1945 he was assigned to the Army and served in Sicily, Italy and Germany.

The military decorations he received include the American Typhus Medal for his work in the control of that disease in Northwest Europe during 1944-45; the Legion of Merit for outstanding work in controlling communicable diseases in the European Theater of Operations; the Order of Public Health from France, and several other foreign decorations.

In 1946 he returned to the National Cancer Institute as assistant chief, and in 1947 was appointed director. He is married and lives in suburban Bethesda, near the Institute. Mrs. Scheele is a dentist and they have three children.

Dr. Scheele is an intense worker—probably partial to research—but has shown outstanding ability as an administrator. He is thoroughly aware of the potentialities of his new position. He is popular with his fellow officers in the USPHS and has a record of accomplishment with the National Cancer Institute. At the age of 40 he is probably the youngest Surgeon General USPHS has ever had. There have been rumblings behind the scenes that Scheele was hardly the seasoned health official required for the onerous job of Surgeon General. He has moved around frequently, a year here, a year there, doing showy jobs and obtaining rapid advancements. But whether he has the administrative experience, the confidence of fellow officers, and the solid foundations needed for the position which Dr. Parran described as "the most important public health position in the world, present or prospective," remains to be seen.

New Bills Introduced

HR5356—Mr. Jackson, Washington, February 12. A bill to provide for a national program of retirement, survivors, and extended disability insurance.

Referred to the Committee on Ways and Means.

Comment: This bill is similar to HR4303—Dingell and S1679—Murray. It extends the coverage under the old age and survivors insurance provisions in the Social Security Act to the self employed, agricultural workers, servicemen, employees of non-profit organizations, and employees of State and

ocal government. The retirement age for women reduced from 65 to 60, and the amount of ermitted earnings by the beneficiaries is increased rom $15 to $50 monthly. An increase is made n the amount of earnings taken into account n benefit computations from $3,000 to $4,800 an-ually, and in the monthly benefit for retired work-rs. There is established a National Social Insurance dvisory Council of twelve men and women, ap-ointed by the Federal Security Administrator, epresenting employers and employees in equal umber. The Federal Security Administrator shall et as chairman of the Council, ex officio. The ouncil is to make policy recommendations to the ederal Security Administrator.

HR5399—Mr. Kean, New Jersey, February 16. A bill to increase the benefits payable under the ederal Old Age and Survivors Insurance System, o liberalize the eligibility provisions of such system, o extend the coverage provisions of such system to he self employed, employees of non profit institu-ions, agricultural labor, and, under voluntary com-acts, to employees of State and local governments, nd for other purposes.

Referred to the Committee on Ways and Means.

Comment: Following closely the proposals made y the Social Security Administrator, in his annual eport to Congress, Mr. Kean introduced this meas-re, which would extend the coverage of the Fed-ral old age and survivors insurance program to all vorkers, including domestics, farm workers and elf insured; excepting only the railroad workers nd members of the Armed Forces. The bill in-reases the amount of earnings to be taken into ccount in benefit computations from $3,000 to 4,200. It will boost the amount of permitted earn-ngs by beneficiaries from $15 to $30.

H.Res.466—Mr. King, California, February 9. A esolution, instructing the Committee on Interstate nd Foreign Commerce of the House, to formulate, onsider, and report to the House of Representa-ives, appropriate legislation, authorizing the U. S. ublic Health Service to establish and finance medi-al scholarships in recognized medical schools of the J. S., in order to encourage and increase the num-er of medical school graduates to meet the esti-nated essential demand for doctors in the various overnment agencies and the nation at large.

S2189 by Mr. Saltonstall, of Massachusetts, Feb-uary 20. A bill to assist the States in the develop-ment and maintenance of local public health units, and for other purposes.

Referred to the Committee on Labor and Public Welfare.

Comment: This bill would extend Federal subsidy to the States for developing and maintaining local public health units organized to provide basic full time health services, and to train personnel. The States, in order to participate, would be required to submit a plan to the Surgeon General for approval. The Surgeon General shall determine the amount of subsidy and, with the approval of the Federal Security Administrator, by regulation prescribe—"(1) criteria for determining the minimum population and financial resources which various types of areas must have, and the minimum number and types of full time professional and other personnel which local public health units in various types of areas must employ per thousand population, in order to afford reasonable assurance of continued financial support for, and efficient and economical administration of, basic public health services in such areas; (2) criteria for determining whether methods for allocating, under State plans, the funds made available under this Act to local public health units are equitable and such as to assure the effective use of such funds in the provision of basic public health services; (3) subject to the limits set forth in section 6 (a)(5), general methods of administration necessary to assure efficient and economical provision of basic public health services under State plans, including the conditions under which compliance with such methods may be postponed; (4) types of health services, including the training of personnel for local public health work, which shall be considered basic public health services for which funds may be expended under State plans."

In order to be approved, the State plan shall: (1) assure coverage of all areas in the State; (2) contain satisfactory evidence that the State health authority will have authority to carry out the plan; (3) provide that each local public health unit shall be assured of continued financial support and employ a sufficient full time personnel; (4) assure equitable distribution and effective use of the provided funds; (5) provide for the establishment and maintenance of personnel standards on a merit basis; (6) submit such reports as the Surgeon General may from time to time require. The Act shall be administered by the Surgeon General under the supervision and direction of the Administrator and for this purpose

"the Surgeon General is authorized to make such administrative regulations and perform such other functions as he finds necessary to carry out the provisions of the Act."

Tentative drafts of this bill were approved by the State and Territorial Health Officers at a recent conference in Washington and a resolution supporting such legislation was adopted by the National Congress of Parents and Teachers.

S2215 by Senators Bridges, New Hampshire; Ives, New York; Pepper, Florida; and Murray, Montana; February 25. A bill to provide for research and control relating to diseases of the heart and circulation.

Referred to the Committee on Labor and Public Welfare.

Comment: This bill is similar to HR5087 and HR5159. It establishes a National Heart Institute under the Public Health Service and provides for Federal support to research and control of diseases of the heart and circulation. The amount to be appropriated to carry out this function, has been left up to Congress.

SJRes.191 by Mr. Holland, of Florida, February 26. (Referred to the Senate Committee on the Judiciary.)

HJRes.334 by Mr. Hobbs, of Alabama, February 24. (Referred to the House Committee on the Judiciary.)

Identical resolutions, giving the consent of Congress to the compact on regional education entered into between the Southern States at Tallahassee, Florida, on February 8, 1948.

Comment: These resolutions were introduced as enabling measures which would allow for the constructive cooperation of the participating States and the joint use of public funds derived from taxation from the constituent States, in the planning, establishment, acquisition and operation of educational institutions for both white and negro students in the States within the compact. Governor Caldwell of Florida, who presided at the meeting of the State Governors, held in Washington, urged the utmost speed in the endorsement of the compact by Congress because one of this country's two negro medical schools (Meharry Medical College at Nashville, Tenn.) will be forced to close at the end of this fiscal year unless it receives financial support.

HR5468 by Mr. Patterson, of New Jersey, February 19. A bill to authorize the appointment of doctors of chiropractic in the Department of Medicine and Surgery of the Veterans' Administration.

Referred to the Committee on Veterans' Affairs.

Comment: This bill seeks to amend Public Law No. 293, of the 79th Congress—"An Act to establish a Department of Medicine and Surgery in the Veterans Administration" by adding the following new section to that portion which states the eligibility of doctors of medicine and osteopathy for appointment in the Department of Medicine and Surgery: "Hold the degree of doctor of chiropractic from a college or university approved by the Administrator, be licensed to practice chiropractic in one of the States or Territories of the United States or in the District of Columbia, and have practiced chiropractic for a period of at least two years." Chiropractors are licensed to practice chiropractic in most of the States and veterans have been educated at chiropractic schools under the G.I. Act. None of these schools, so far as our information goes, deserves classification as a college or is a portion of a university. The final determination of the worth of the schools is left to the Administrator of the Veterans Administration.

HR5494 by Mr. Cole, of New York, February 23. A bill to provide dental treatment for dependents of Naval and Marine Corps personnel, and for other purposes.

Referred to the Committee on Armed Services.

Comment: The measure seeks to provide hospitalization and dental care and treatment in authorized naval hospitals and dispensaries for the dependents of Naval and Marine Corps personnel.

HR5532 by Mr. Heselton, of Massachusetts, February 24. A bill to establish a National Science Foundation.

Referred to the Committee on Interstate and Foreign Commerce.

Comment: Mr. Heselton reintroduced S526, in the form it was when vetoed by the President, with this statement, "I have reintroduced the bill as it was reported in the conference report so that we may review both the consideration of the legislation in the Congress last year in terms of the reasons given for its disapproval by the President and the precedence to which reference is made in the memorandum."

HR5644 by Mr. Dolliver, Iowa, March 1. A bill to assist the States in the development and mainten-

ance of local public health units, and for other purposes.

Referred to the Committee on Interstate and Foreign Commerce.

Comment: Companion House Bill to S2189.

Action On Bills

S1454—To amend the Public Health Service Act—Substituted in lieu of the House Companion Bill, HR3924. Passed the House, February 16. It provides for the reorganization of the personnel of the Public Health Service, to conform with the plan recently adopted by the Army and Navy. The osteopaths were successful in securing recognition similar to that accorded them by the VA and the Navy.

S140 and S472—Reached on the Senate calendar and passed over without prejudice for the third time.

S1454—To amend the Public Health Service Act with regard to certain matters of personnel and administration—was approved February 28, including the osteopathic clause and becomes Public Law No. 425.

HR4090—To equalize retirement benefits among members of the Nurses Corps, the Army and the Navy. Reported in the House with an amendment (H.Rept. No. 1429) February 26.

HR4739—Free importation of exposed x-ray film—passed the House as amended by the Committee.

Hearings

S1570—To equalize nurses' retirement benefits—The Senate Armed Services Committee began hearings on February 23, and the hearings are still in progress.

HR4200—Dental research—The House Committee on Interstate and Foreign Commerce scheduled public hearings for March 11 and 12, on the proposed National Institute of Dental Research.

HR4163—Hospitalization for seamen—The House Committee on Interstate and Foreign Commerce opened hearings on March 10.

Appropriations

The House and Senate have passed an urgent deficiency appropriation and in it was provided $15 millions to remain available until expended, in order to liquidate contractual obligations authorized to be incurred during the fiscal year of 1948, or any subsequent fiscal year, for hospital construction grants. There is also provided $1,888,600 to carry on the functions of the Commission on Organization of the Executive Branch of the Government.

SOCIAL SECURITY ADVISORY COMMITTEE

A resolution was introduced in the Senate to increase by $25,000 the limit of expenses authorized for the advisory committee of the Senate Finance Committee, studying the Social Security Act.

STATUS QUO OF SOCIAL SECURITY

In accordance with a decision of the Supreme Court, the Department of Internal Revenue extended the Social Security coverage to probably 750,000 people who were not eligible prior to this action of the Court. The House considered and adopted a joint resolution (HJRes. 296) which reestablishes the definitions of "employer" and "employee." It was argued that, under the Court's definition, self employers and operators of private businesses might be required to register with the Social Security Bureau. Examples given were insurance agents and Fuller Brush salesmen. Proponents of the resolution stated that, when social security coverage was to be extended, appropriate legislation should be indicated rather than attempt to have it done through Court decision.

GROUP HEALTH ASSOCIATION

The organization in Washington which figured in the AMA's anti-trust suit is having some financial difficulties and its trustees have recommended an increase in rates, but the members in a mass meeting would not endorse the recommendation and instructed the Board to investigate other methods of increasing the income.

Dr. Miller In Washington

James R. Miller, president of the State Society, testified for the AMA at the recent hearings on the Saltonstall school health services bill held by the health subcommittee of Senate Labor and Public Welfare Committee. Dr. Miller expressed opposition to the bill which would authorize Federal funds for prevention, diagnosis and treatment of diseases and mental and physical defects of school age children. This bill if passed provides no means test and would cost the Treasury an estimated $25,000,000 for the first 2 years, with an initial appropriation of $10,000,000 to be expended through the Children's Bureau.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

VA Reduces Personnel

The Veterans Administration will reduce its personnel by approximately 8,500 employees before the end of the current fiscal year, June 30, 1948. The planned reductions are to be made in Services other than medical. No decreases are contemplated in the VA medical program for the balance of this fiscal year. In VA's recommended budget for the fiscal year 1949, an increase is proposed in the medical program. The total cut of 8,500 employees is divided into two main categories: (1) for the field installations throughout the United States and its possessions, and (2) for Central Office in Washington and the New York Branch of Central Office.

New Regulation For Vocational Rehabilitation

A new regulation issued by the Veterans Administration extends to all World War II veterans qualifying for training under the Vocational Rehabilitation Act (Public Law 16) the reduced-time training privileges previously limited to two groups of disabled trainees.

These two groups were composed of veterans whose disabilities would never permit full-time training and veterans suffering from arrested pulmonary tuberculosis.

Any seriously disabled veteran, unable to devote as many hours per day to training as the ordinary veteran trainee does, now may qualify for full-time training under specified conditions. They are:

(1) The VA medical consultant determines that the nature of the trainee's disability will not permit him to devote as many hours to training as the ordinary trainee does.

(2) The veteran's individual training program requires as many hours per day for training as the medical consultant determines his disability will permit.

(3) There is good promise that the veteran's work tolerance will increase more rapidly if he is in training for a suitable employment objective than if he were not taking any training.

(4) The hours of the reduced-time training program will be increased gradually as the veteran's work tolerance increases until he is taking a normal training program. Expert medical advice must be sought before any increase is made in the number of training hours. The first increase in training hours must be made within three months after the veteran enters the reduced-time training program.

Those disabled veterans whose work tolerance does not increase after three months will be withdrawn from training under the new program and considered for training under the former reduced-time standards which still prevail.

These standards require that the amount of time devoted to training must be as great as the medical consultant determines a veteran's disability ever will permit. The course is regarded as full-time training if it will restore the veteran's employability; if it can be completed in the statutory time; and if there is no other appropriate course to which the individual trainee can apply a greater amount of training time.

New VA-NP Head

Appointment of Dr. Harvey J. Tompkins as head of the neuropsychiatric service in Veterans Administration Department of Medicine and Surgery has been announced by Dr. Paul B. Magnuson, chief medical director.

Dr. Tompkins succeeds Dr. Daniel Blain, who has resigned to accept the position of medical director of the American Psychiatric Association. Dr. Blain has been chief of VA's neuropsychiatric service since November 1945. He will continue to serve VA's chief medical director in an advisory capacity.

Dr. Tompkins is a graduate of Loyola University Chicago. He interned at Mercy Hospital, Chicago, and joined the VA in 1935. Since 1945 he has been assistant chief of the neuropsychiatry division and chief of the inpatient (hospital) section at the VA

central office in Washington. He also is associate professor in psychiatry at Georgetown University School of Medicine and a diplomate of the American Board of Psychiatry.

Interns and Residents Get No Raise in Allowance

Veterans taking internship and residency training under the Servicemen's Readjustment Act (G.I. bill) and the Vocational Rehabilitation Act (Public Law 16) are not entitled to increased subsistence allowances authorized under a recently enacted law.

The higher rates are available only to veterans in schools, colleges and universities pursuing full-time courses of education.

Interns and residency trainees will continue to receive subsistence payments at the old rates of $65 a month for those without dependents and $90 for those with dependents.

The new rates for full-time veteran students are $75 a month for a veteran without dependents, $105 for a veteran with one dependent, and $120 for a veteran with more than one dependent.

VA To Take On More Part Time Physicians

VA branches have been ordered to transfer as many full time physicians as possible from regional offices to hospital duty. These physicians will replace hospital staff physicians whose terms of service are terminating. To fill the vacancies thus created in the regional offices, part time physicians will be hired. This latter group will be acceptable even though they may be able to devote only 5 to 10 hours a week to VA duties. Preference will be given recent graduates. VA is also opening its hospitals to physicians working out their final clinical requirements for examination by specialty boards.

Connecticut War Veterans

The population of war veterans in Connecticut now totals approximately 282,000, according to an estimate recently announced by Harry T. Wood, manager of the Hartford Regional Office of the Veterans Administration. Of this total, 51,000 are veterans of World War I and other wars, as compared with approximately 231,000 World War II veterans. New England has an estimated total of 1,286,000 veterans of all wars, and the estimated veteran population for the country is now close to 18,500,000, according to the Veterans Administration.

VA Hospital Census

As of January 31, 1948 the Veterans Administration counted 109,018 patients in hospitals. 94,948 of these were in VA hospitals and 14,070 in non VA hospitals. The striking fact, however, is that of these patients in VA hospitals 66⅔ per cent were there for non service connected disabilities. Of the patients in the non VA hospitals 57 per cent were there for non service connected disabilities.

Medical Advisory Committee For Veterans Employment

A Medical Advisory Committee has been appointed by the State Medical Society to cooperate with the Veterans Employment Service and the Connecticut Employment Service in connection with the placement of physically handicapped persons.

Chairman of the new committee is Bliss B. Clark, of New Britain, and its members include Charles I. Solomon, Meriden; Arthur C. Unsworth, Hartford; Robert V. Nespor, Westport; and Russell V. Fuldner, New Haven.

Recently the initial meeting of committee members and representatives of the employment services was held in New Haven, and plans for the development of an advisory program were discussed. Present at the meeting were Mr. William G. Ennis, director of the Connecticut State Employment Service; Mr. Arthur V. Geary, Veterans' employment representative for Connecticut; and Mr. Vincent P. Hippolitus, assistant Veterans' employment representative.

Physician May Become WMA Founders

It is possible now for individual physicians to become founder members of the American Committee in Support of the World Medical Association. The fee is $10 a year and checks may be made payable to the Secretary of the American Committee in Support of World Medical Association. The checks are to be sent to Dr. Louis H. Bauer, a member of the AMA Board of Trustees, New York Academy of Medicine, 2 East 103d Street, New York 29, N. Y.

Scholar in Medical Science Program Announced by Markle Foundation

An opportunity to start a career in academic medicine is offered to young scientists with the necessary training to hold a regular faculty appointment and to conduct original research through a new program of "post fellowship" grants, announced by the John and Mary R. Markle Foundation. The purpose of the program, according to John M. Russell, executive director of the Foundation, is to attract much needed talent to academic medicine by giving promising young scientists academic security and financial assistance for a period up to five years. The program will be conducted in cooperation with accredited medical schools in the United States and Canada. Grants of $25,000, payable to the cooperating school at the rate of $5,000 annually for a five year period toward the support of each successful candidate or his research or both, will be available beginning with the academic year 1948-49. If the plan proves successful, the Foundation will appropriate a total of $1,250,000 to the schools by 1953.

Candidates will be recommended by medical schools and will be limited to young men and women with a particularly strong interest in research and teaching in any of the clinical or preclinical sciences or in the sciences basic to medicine. They will have had training in some special field or combination of fields to qualify them to receive a regular faculty appointment and to conduct original research. The final choice will be made, on the basis of the schools' recommendations, by regional committees appointed by the Foundation. The young scientists chosen will be known as "Scholars in Medical Science." No fixed number of Scholars will be appointed in any year, but it is expected that approximately fifty will receive appointments during the five year period. For each Scholar, the school will determine salary and academic rank, encourage research by setting reasonable limits upon teaching and other non research activities, provide laboratory facilities, and, if necessary, make a financial contribution toward the support of his work.

The Scholar program places the emphasis on the personal qualities and scientific and teaching abilities of the men and women chosen, rather than upon particular research projects or teaching fields in which they may be interested. The program is the result of a survey of medical research and education, recently made by the Foundation, which shows that while there are scholarships and other forms of financial aid for the student in the course of his scientific training and while there are funds available to the scientist once his name is made, there are few sources of help at the beginning of the career of the man who chooses academic medicine.

A pamphlet covering the details of the plan has been sent to all deans of accredited medical schools, and persons interested in being considered as candidates are referred to them for further information.

In the first group of 16 young scientists chosen under this plan is Henry D. Hoberman, M.D., of Columbia University and Harvard Medical School. The grant in this instance goes to Yale University School of Medicine on whose faculty Dr. Hoberman holds an appointment. His field of research is biochemistry and more specifically the metabolism of compounds by use of isotope tracers.

Public Health Service Research Fellowships

The Surgeon General of the U. S. Public Health Service has been authorized to establish and maintain research fellowships which are intended to promote the training and development of investigators in the field of medicine and related sciences. The following types of fellowships will be awarded:

1. A predoctorate fellowship is available to qualified applicants who hold a Bachelor's degree. The stipend for successful applicants without dependents is $1,200 and for those with dependents $1,600 per year, with tuition fees paid by the Public Health Service. These fellowships are also granted to medical students who have completed one or two years of their medical cuorse and wish to spend one, two or three additional years in a basic science (biochemistry, physiology, physics, etc.) in preparation for a career in medical research, before finishing their studies toward the M.D. degree.

2. A predoctorate fellowship is available to qualified applicants who have a Master's degree or its equivalent and this fellowship carries a stipend, in addition to tuition, of $1,600 for persons without dependents and $2,000 for those with dependents. As with the foregoing class, these fellowships will also be awarded to medical students.

3. A postdoctorate fellowship is awarded to qualified applicants who hold a Doctor's degree in medicine or related fields. The stipend for this fellowship is $3,000 a year for persons without dependents and

$3,600 for those with dependents, but tuition fees are not provided. Fellows who are reappointed receive an increase of $300 each year.

4. Special research fellowships are available to applicants who qualify for a doctorate fellowship and in addition have demonstrated outstanding ability or have special training for a specific problem. The stipend is determined in each individual case.

Fellowships are awarded for one-year periods and may be renewed. They permit vacations, not to exceed one month, in accordance with the rules of the institution where the work is being done. Progress reports are required at the end of eight months from Fellows who wish to apply for reappointment and at the end of the fellowship year from all others. Fellows are permitted to carry on not more than one hour of teaching or three hours of laboratory instruction per week during one semester only. Fellowships are awarded about every three months, but the effective date for beginning work can be set at any time to suit the convenience of the applicant or of the institution where the work is to be done. The Public Health Service has been advised by the Collector of Internal Revenue that the stipends which the fellowships carry will not be subject to withholding tax.

Forms of application for a research fellowship may be obtained from the Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Maryland. Additional information concerning the awards may be obtained from the Secretary's office.

Preventive Medicine Gets Interim Specialty Board

Consultants and practitioners of preventive medicine, one of the least formalized but most universally important branches of medical science, have learned that a great forward step toward professional recognition of their calling as a distinct medical specialty has been made by the formation of an "Interim Board" of Preventive Medicine. Announcement of the move was made jointly by the Surgeons General of the Army, Navy and U. S. Public Health Service.

War and postwar conditions have emphasized the need for uniformly high standards in the field of public health and preventive medicine, and the Interim Board was formed chiefly for the purpose of setting up certification requirements for medical officers seeking to qualify as specialists. The cooperative effort of these three services will undoubtedly give impetus to a growing demand for creation of an American Board of Preventive Medicine and Public Health to take its place along with the 16 medical specialty boards already in existence and supply the uniform professional standing and protection specialists need in order to function most effectively.

Members of the Interim Board were selected with great care. Several weeks ago the three Surgeons General formed an advisory committee to consider the problem. Through a pooling of recommendations, a panel was formed of men throughout the country who were considered the most distinguished in the field of public health and preventive medicine. From this panel, six civilian authorities on the specialty were chosen and all accepted an invitation to form the Interim Board. They are: Dr. Ernest L. Stebbins, director of Johns Hopkins University School of Hygiene & Public Health; Dr. Wilton L. Halverson, California State Director of Public Health; Dr. Harry S. Mustard, New York City Health Commissioner; Dr. Thomas Francis, Jr., University of Michigan School of Public Health; Dr. Gaylord W. Anderson, director of the University of Minnesota School of Public Health; and Dr. Hugo Muench, assistant dean, Harvard School of Public Health. Chiefs of the preventive medicine divisions of the Army and Navy and an officer selected by the Surgeon General of the Public Health Service, complete the roster. They are: Dr. James Crabtree, Deputy Surgeon General, U. S. Public Health Service; Colonel Tom F. Whayne, Chief, Preventive Medicine Division, Office of The Surgeon General, U. S. Army, and Captain Otto L. Burton, Chief, Preventive Medicine Division, Bureau of Medicine and Surgery, U. S. Navy.

At its first meeting the Interim Board began drafting a preliminary bill of requirements for certification and elected Dr. Stebbins chairman. It is expected that official standards for qualification as a specialist in preventive medicine will soon be achieved.

Schering Grants Twelve Endocrine Research Funds

Mr. Francis C. Brown, president of Schering Corporation, of Bloomfield and Union, N. J., announced that a substantial program of grants in support of

medical research studies has been initialed by that corporation, manufacturers of endocrine, x-ray diagnostic, chemotherapeutic and pharmaceutical products.

The use of endocrine preparations in neuropsychiatry will be studied at the Worcester Foundation of Experimental Biology, Worcester, Mass., by Dr. Hudson Hoagland, and at the Montefiore Hospital's Division of Neuropsychiatry, New York City, under the direction of Dr. H. Houston Merritt, professor of clinical neurology at Columbia University, College of Physicians and Surgeons and Dr. Arnold P. Friedman.

The value of hormones in treatment of internal bleeding and threatened abortion is to be investigated by Dr. Abraham Rakoff at Philadelphia's Jefferson Medical College and Hospital. Drs. Howard C. Taylor, Earl T. Engle and C. L. Buxton, professors of obstetrics, gynecology and anatomy, of Columbia University, College of Physicians and Surgeons, will study sterility in females and early abortion. Investigation of the relationship of the adrenal gland to pregnancy and toxemias of pregnancy will be directed by Dr. Charles W. Lloyd, associate professor of medicine, at Syracuse University College of Medicine.

Three New York medical schools have been given grants to support studies on endocrines in the field of skin disorders, in prepubescent youths, and to develop a new method of administration of estrogens. Dr. Frederick Reiss, associate professor of dermatology at New York University, College of Medicine, will plan the first program; the second at Columbia University's College of Physicians and Surgeons is under Dr. William A. Schoenfeld; and the last will be directed by New York Medical College's professor of clinical medicine, Dr. Thomas R. McGavack.

Dr. Harrison F. Flippin, chairman of the committee on chemotherapy at Philadelphia General Hospital, will supervise the study of combined sulfonamide therapy in injections. Dr. Abraham Cohen of the Philadelphia General and Jefferson Hospitals will continue his study of the use of gold combined with estrogens and androgens in arthritis.

Dr. Walter M. Kearns, Milwaukee, Wis., continues for another year certain special research studies.

A large grant was given to the Massachusetts General Hospital, Boston, to support that institution's general research program.

Foreign Medicine "Hungry" For Modern Concepts

The American medical profession should take steps to aid the faculties of foreign universities in installing creditable facilities to teach modern concepts of preventive and constructive medicine, Dr. Robert Collier Page, general medical director, Standard Oil Company (N. J.), said recently upon his return from a three month's worldwide tour by air.

Dr. Page, also an associate clinical professor at New York University College of Medicine, announced that every doctor he met during his tour was "hungry" for medical literature of all types and that, in his observation, the wrong type of such literature had been finding its way abroad.

"For example," he said, "spectacular statements regarding the efficacy of new drugs after application to only two cases, and miraculous claims for the use of streptomycin as a cure for tuberculosis, etc., which have appeared in our press for lay consumption, have caused irrevocable damage, and deaths have not infrequently occurred through the misguided use of such medications."

In reviewing medical problems in general, Dr. Page was emphatic in stating that, in his opinion, the future of health in both the middle and far eastern parts of the world is dependent completely upon the degree of vigor with which the medical profession per se, and local health authorities promulgate known facts in the realm of preventive and constructive medicine.

"Malnutrition, poor housing and inadequate sanitation are prevalent factors everywhere," he said, "resulting in health deficiencies of all kinds—tuberculosis taking a particularly heavy annual toll."

Dr. Page praised the achievements of the directors and faculty of the University of Beirut, in Lebanon, characterizing it as "typically American in appearance and standards."

A.M.A. Journal Cautions Against Use of Mineral Oil in Food

High prices and the scarcity of edible vegetable oils have caused many restaurants to use mineral oil in food, according to the August 24 issue of *The Journal of the American Medical Association*, which warns that this practice is harmful to patrons. The *Journal* says:

Attention has been called recently to the occurrence of fecal incontinence (diarrhea) due to the ingestion of excessive quantities of mineral oil by unsuspecting patrons of restaurants where mineral oil has been substituted for edible oils in salad dressings. The Council on Foods and Nutrition called attention to the harmful effects of mineral oil in foods in the following paragraph:

It has been shown that the ingestion of liquid petrolatum is capable of interfering seriously with the absorption of carotene, vitamin D, calcium and phosphorus and vitamin K. The effects of its prolonged use have not been thoroughly investigated, but there is sufficient evidence of possible harmful effects to justify the conclusion that its indiscriminate use in foods or in cooking is not in the interest of good nutrition, and any such use should be under careful supervision of a physician.

In reply to inquiries about the legality of mineral oil in salad dressings the Food and Drug Administration has expressed the opinion that "mineral oil salad dressings must be regarded as adulterated under the Federal Food, Drug and Cosmetic Act under any form of labeling employed." Mineral oil should certainly not be used except under the supervision of a physician familiar with the problems involved and should not be used indiscriminately in foods.

Prepare Recordings On Physical Medicine

The Bureau of Health Education of the AMA, in cooperation with the Council on Physical Medicine, has prepared a series of 13 electrical transcriptions devoted to various phases of physical medicine. Distribution of these records began March 15. The recordings are 14 minutes and 30 seconds in length.

The topics include infantile paralysis, massage, exercise, local applications of heat and diathermy, sunlight—real and artificial, hearing aids, radioactive substances, occupational therapy, oxygen in medicine, shoes and artificial limbs, physical treatment in psychiatry, and skin, hair and electrolysis.

These transcriptions are loaned to local medical societies or are for use in broadcasting projects approved by such societies. They are loaned without cost, except that borrowers are requested to pay the return transportation. The series will be loaned as a whole only and no authorization will be given to broadcast individual selected records. Local groups borrowing the transcriptions are expected to make all local arrangements for radio time and for publicity and are likewise expected to take the responsibility for the prompt return of the records when finished.

The Bureau of Health Education now has more than 200 health education transcriptions available for loan and new ones are constantly being added. For further information, address the bureau and request the radio handbook and transcription listings.

AMA Board of Trustees Meets

The AMA Baord of Trustees, meeting in Chicago recently, authorized the National Conference of County Medical Society Officers to sponsor another "Grass Roots" Conference during the annual AMA session in Chicago. The conference will be held on Sunday, June 20.

The board elected Dr. Stanley J. Seeger, of Dallas, Texas, chairman emeritus of the Council on Industrial Health.

Several members of the board met with representatives of the American College of Surgeons to work out certain problems connected with the inspection of hospitals and of graduate training in hospitals. A sub-committee was appointed, the representatives of the AMA being Dr. Harvey Stone, Baltimore, and Dr. Donald G. Anderson, secretary of the Council on Medical Education and Hospitals. Committee members of the American College of Surgeons will be announced later.

Also serving on the committee will be two representatives of the Surgical Specialty Board, Dr. Warfield M. Firor, Baltimore, and Dr. Guy Caldwell, New Orleans, and Dr. B. R. Kirklin, Rochester, Minn., secretary of the Advisory Board for Medical Specialties.

Employees Retirement Plan

Any state or local medical society interested in establishing a retirement plan for its employees may communicate with the National Health and Welfare Retirement Association, 15 Maiden Lane, New York 7, N. Y.

Although this retirement association has been in operation for only two years, about 2,000 health and welfare organizations have enrolled their employees. These include many hospitals and nursing organizations.

The retirement association is a non profit organi-

zation, incorporated under the insurance laws of the State of New York. For tax reasons, membership is limited at present to societies which are classified by the Internal Revenue Bureau under Section 101 (6) of the Revenue Code, which lists the various organizations exempt from taxation. There is no restriction as to the size of the staff. A society with only one employee is eligible.

Sixty Now Included Under Seal of Acceptance

During the Interim Session of the AMA in Cleveland the Council on Medical Service granted the Seal of Acceptance to six voluntary prepayment medical care programs. They are:

Surgical Service Plan of Hospital Service, Inc., Fort Collins, Colo.

South Dakota Injury-Illness Expense Plan, Sioux Falls, S. D.

The Wisconsin Plan, Madison, Wis.

The Wisconsin Physicians Service, Madison, Wis.

Surgical Care, Milwaukee, Wis.

Hawaii Medical Service Association, Honolulu.

The approval of these plans brings the total number of "Accepted" plans to sixty. Several applications are pending and will be considered in April or June.

New Yorkers Will Lose $40,000,000 From Common Cold in 1948

Statisticians of the New York City Health Department estimated recently that New Yorkers will suffer, collectively, 205,000 years of distress from colds in 1948, and at the same time lose $30,000,000 in earnings because of absence from work.

Adding a conservative $10,000,000 for doctor's bills and medicine, the health department estimates a total of $40,000,000 as the total loss to the 3,450,000 employed persons in the city, with colds credited with one-third of an estimated average absenteeism of one day per person.

The statisticians, as reported by the *New York Times*, arrived at the figures by allowing each of the 7,500,000 New Yorkers two colds this year, and five days for each cold. The average daily wage was estimated at nine dollars.

AMA Warns Against Enrollment in Foreign Medical Schools

One of the speakers at the Federation of State Medical Boards, meeting in Chicago recently, deplored the fact that the Veterans Administration had now approved foreign medical schools which veterans could attend under the GI Bill of Rights.

He sounded a stern warning that graduate students of those schools faced eventual disappointment because they would not be eligible for licensure in the United States.

It might be well for physicians to pass this warning along to any veteran contemplating medical study abroad.

South Carolina News Letter

The secretary of the South Carolina Medical Association in addition to his other Association duties as well as his large pediatric practice, now issues a monthly News Letter! Printed on both sides of an 8½" x 11" sheet, the November issue contains South Carolina and AMA news of the moment, all of which might well be included in the Journal of that State Association, as is done in many other states. Perhaps Secretary-Editor Price is having printer troubles and finds his Journal too long in the making.

THE HOSPITAL PROGRAM

The Hospital Survey and Construction Act, which became law in August 1946, has launched the most comprehensive program in the history of this country for the construction of hospitals and health facilities. To help communities realize the benefits of this legislation, the U. S. Public Health Service has just issued a series of five pamphlets.

"The Hospital Survey and Construction Act" is a summary of the law and regulations. "Why We Need More Hospitals" gives the story of hospital needs in this country. "The Hospital Act and Your Community" tells in simple terms what the program means to states and communities. "Hospital Quiz" is a series of questions and answers on hospital planning. "What is a Hospital System?" describes a coordinated hospital system, intended to extend the scope of hospital care. Sample copies of these pamphlets are available free on request to the U. S. Public Health Service, Washington 25, D. C.

MILITARY BIOGRAPHIES

These brief sketches of military experience of members of the Society have been compiled from data taken from questionnaires completed by each medical officer. Biographical material for some officers is lacking because questionnaires were not returned.

ROGER SHERMAN DOWNS

Died in Service

Roger Sherman Downs was born in Saratoga Springs, New York in 1910, graduated from Williams College in 1932 and received his M.D. from Harvard in 1936. He served as an intern at the Strong Memorial Hospital, Rochester, New York, and completed a fellowship at the Peter Bent Brigham Hospital, Boston. He first settled in practice in Farmington, Connecticut and later removed to Litchfield where he resided when he was commissioned Lieutenant (j.g.) in the Medical Corps of the Regular Navy in 1942.

After joining the Navy, Dr. Downs received training in diving and under-water salvage and served in North Africa, Sicily and Italy. He returned to the United States early in 1945 and with Mrs. Downs (Elinor Fosdick Downs, M.D.) was living with his father-in law, Harry Emerson Fosdick, D.D. He was found dead in bed from an apparent attack of coronary thrombosis on February 6, 1945.

LUTHER CALDWELL HEIDGER

Lost in Action

Luther Calwdell Heidger was born in Philadelphia on April 23, 1897. When a small boy he removed with his family to a farm in Greensboro, Vermont where he received his early education. Dr. Heidger did his preliminary work at Muskimgum College, New Concord, Ohio, and received his M.D. from the University of Vermont in 1921. Following this, he was an intern at the Bridgeport Hospital and settled in practice in Stratford where he continued until he entered military service on September 7, 1940. On February 12, 1936 he married Bessie C. Young, Assistant Superintendent of the Bridgeport Hospital.

Dr. Heidger's first assignment was Captain, Medical Corps, Fort H. G. Wright, Fishers Island, New York, attached to the 242nd Coast Artillery. In February 1941, at his own request, he was transferred to Randolph Field, Texas to take training as a flight surgeon. He also served at Jacksonville, Florida and Albuquerque, New Mexico where he was promoted to Major and assigned to the 19th Bombardment Group.

In October 1941, Major Heidger went to the Philippines and was stationed at Clark Field at the time of Pearl Harbor. Without regard for his own safety, Major Heidger administered to the men at Clark Field during the Jap bombardment and received the Distinguished Service Cross and was also the recipient of the Air Medal with two citations for flying with a bomber group under hazardous conditions. At the fall of the Philippines, Major Heidger became a prisoner of the Japanese and was confined at Davao Penal Colony.

While being removed from the Philippines, he was lost in the sinking of a Japanese Ship in the South Pacific on September 7, 1944. A survivor of this sinking wrote afterwards, "In all the heat, sickness, and lack of food, he continued his sick calls day and night going around visiting the men and risking his life, He never lost control of himself and worked sacrificially to carry out his duties as physician to the weak. I will never forget his figure standing up in the middle of the hole with an old hat on his head and chewing a ragged piece of cigar. I believe I will always consider him the finest doctor I have ever known."

ABRAHAM JOSEPH LEON

Died in Service

Abraham Joseph Leon was born in New York City on December 9, 1902 and later removed with his family to Westerly, Rhode Island where he received his preliminary education. In 1928, Dr. Leon received his medical degree Magna Cum Laude from Tufts, standing second in his class. He served an internship at the Southern Baptist Hospital, New Orleans and at the Jersey City Hospital. In 1930 he was certificated by the National Board of Medical Examiners and settled in practice in Mystic. In 1932, he married Helen Cutler of Flushing, Long Island. Dr. Leon was an accomplished pianist and active in the affairs of the Mystic Art Association.

Early in the war, Dr. Leon served as Chief Medical Officer of civilian defense in his area and organized a group of first-aid stations.

In spite of a history of poor health, Dr. Leon insisted on entering military service and was accepted and commissioned a Captain in the Medical Corps of the Army in July 1942. He served at various posts in this country and was assigned to a hospital combat unit preparatory to overseas duty. Soon thereafter, he developed attacks of angina pectoris and was assigned to the Walter Reed Hospital. His condition became progressively worse and he was given sick leave. He died at his home on June 21, 1943 from coronary occlusion.

PAUL LANGE PHILLIPS

Died in Service

Paul Lange Phillips was born in Brooklyn, New York on December 16, 1904, graduated from Bowdoin College and received his M.D. from Cornell University College of Medicine in 1930. In 1932-33, Dr. Phillips studied nueropathology and clinical neurology in Germany. He then returned to this country and served as resident in neurology and in July 1934 joined the staff of the Institute of Living in Hartford as resident in psychiatr continuing at the Institute until October 1940 when he was commissioned in the Medical Corp, United States Navy. After joining the Navy, Commander Phillips served at the Naval Air Station, Norfolk, at the Marine Air Corps Station at Parris Island, South Carolina, and on the carriers, Kasaan Bay and Wake Island. He also participated in the invasions of Luzon, Iwo Jima, and Okinawa. Dr. Phillips died in Norfolk, Virginia, on May 11, 1947 and was buried in Arlington National Cemetery.

FRANK REICHENBACH

Lost in Action

Frank Reichenbach was born in Woodbury, Connecticut April 30, 1909. He received his preliminary education in the Woodbury High School and graduated from Tufts Medical College in 1933. Following this he served as an intern and resident at the Waterbury Hospital and in 1935 commenced practice in Woodbury. A year later, he removed to Watertown and became associated with Dr. Edwin G. Reade. In 1938, he took a fourteen months' leave of absence for postgraduate study in cancer therapy at the Westfield Cancer Hospital, Westfield. Massachusetts. Continuing his interest in cancer, he was active in the Waterbury Hospital Tumor Clinic and organized the outpatient tumor clinic at the Chase Memorial Dispensary and was active in the affairs of the local branch of the state cancer society. On April 15, 1931 he was married to Ellen Olsen of Brockton, Massachusetts. Dr. Reichenbach was commissioned Lieutenant Medical Corps, United States Naval Reserve on July 5, 1943 attached to the Seabees at Davisville and Newport, Rhode Island and Lido, Long Island. He left for overseas on July 23, 1944 as Senior Surgeon to the 114th Construction Battalion and was killed in a mine explosion on November 6, 1944 in the Cherbourg area of France.

On September 22, 1944 Dr. Reichenbach wrote a letter to the State Medical Journal which was in the press at the time of his death and he concluded: "War is destructive. In the final analysis, there is no victor. Unfortunately, at times it is necessary to do battle to stifle a few mad men. I think every medical man gives his services willingly and cheerfully in an attempt to alleviate the suffering inflicted by these self-styled saviours of the human race, realizing the futility of war and wishing with all his heart that he could get home to his family and friends."

PHILIP JOSEPH SAVAGE

Died in Service

Philip Joseph Savage was born in New London, Connecticut on June 9, 1893. He received his preliminary education at St. Mary's Parochial School and Bulkeley High School, New London. He then attended Colgate University and received his M.D. from the University of Maryland in 1921. Dr. Savage settled in practice in New Londin and served as assistant obstetrician on the staff of the Lawrence and Memorial Hospitals and later gave up his practice and studied ophthalmology at the Royal London Eye and Ear Hospital, Englnad. Following this training, he returned to New London and engaged in the practice of ophthalmology.

Major Savage took an early interest in military service and served with the Depot Brigade during World War I and in August 1927 was commissioned as a Captain, Medical Corps, in the Connecticut National Guard attached to the 192nd Field Artillery. He continued in the National Guard and was inducted into federal service February 1941 as a Major, Medical Corps, assigned to the 43rd Division at Camp Shelby, Mississippi. Later Major Savage was assigned to the Army Air Corps. He saw duty in England and was in the invasion of Africa. While in Africa, he contracted amebic dysentery and his health gradually failed. For a long time he was at home on sick leave following a colostomy and died, August 2, 1945 of neoplasm of the rectum.

RICHARD EDWARD SHEA

Died in Service

Richard Edward Shea was born in Willimantic, Connecticut, September 28, 1906. He received his preparatory education in the public schools of Willimantic and entered Tufts College from which he transferred to Yale where he received his B.S. degree in 1927 and his M.D. from Yale in 1930 and served an internship at Grace Hospital, New Haven.

In 1932, he established himself in general practice in Willimantic and on May 29, 1943, he was married to Elsie Normandin.

Dr. Shea was commissioned a First Lieutenant in the Medical Corps of the Army on May 17, 1943. After serving six months in this country, he was assigned to the Army Air Forces and served twenty-two months in India and Okinawa and was promoted to Captain and Major. In the autumn of 1945, he was returned to the United States for a well deserved leave and three weeks later, he died suddenly on November 9, 1945 at his home.

BEY, EDWARD A., New Haven; b.)4; Georgetown 1930; Army Air— ıe 30, 1942 Major, Lt. Colonel Sepıber 1, 1943, Colonel December 8, [4; Service Terminated March 24, [6; Duty—Air Transport Command, rth Africa; Caribbean; India-China; ıool of Aviation Medicine; School of plied Tactics; School of Tropical dicine; Awards—Air Medal; Distinshed Flying Cross; Bronze Star. Reved to Florida.

RAHAMS, MYER, New Canaan; b.)8; Tufts 1931; Army August 27, '2 Lt., Captain February, 1943; Service rminated January 1946; Duty—Conental United States.

RAHAMSON, ROBERT H., Stamd, (Entered service from New York City); b. 1903; McGill 1930; Navy October 1941 Lt., Lt. Cmdr. October 1943; Service Terminated March 1, 1946; Duty—U. S. Naval Hospital, Brooklyn, N. Y.; 10th Naval District; San Juan, Puerto Rico; U. S. Marine Corp, Parris Island; U.S.N.H. Sampson, N. Y., Noroton Hts., Conn.

ABRASHKIN, MORTIMER D., New Haven; b. 1907; Maryland 1932; Army—February 24, 1941 Captain, Major February 17, 1944, Lt. Col. February 13, 1946; Service Terminated May 31, 1946; Duty—Camp Blanding, Fla., Hawaiian Islands, Camp Cooke, Calif.; New Caledonia; Guadalcanal; Palau Islands; Philippine Islands; Japan; Halloran General Hosp., N. Y.; Awards—Asiatic-Pacific Medal w/2 battle stars; Philippine Liberation Medal w/1 battle star.

ADAMS, ARTHUR J., Torrington; b. 1911; Indiana 1938; Army—July 30, 1941 Lt., Captain June 9, 1942; Service Terminated January 10, 1946; Duty—Carlisle Barracks, Pa.; O'Reilly General Hospital, Springfield, Mo.; 2nd Aux. Surg. Gp.—Tunisia-Sicily-Naples-Foggia; Rome-Arno-Southern France-Rhineland-Central Europe (North Africa-Mediterranean-Middle Eastern Theatres of Operations); 36th General Hospital, Paris, France; Award—7 battle stars.

AGRIN, ALFRED, Norwich; b. 1919; Tufts 1943; Navy—December 30, 1943 Lt. (j.g.); Service Terminated August 31, 1946; Duty—Asiatic-Pacific Theatre; USS Grundy; Naval Hosp., Newport, R. I.

AIELLO, LOUIS J., New Haven; b. 1910; Boston University 1935; Army—January

1, 1942 Lt., Captain July 17, 1942; Service Terminated January 30, 1946. Duty—North Africa, Italy, Corsica; Award—Bronze star.

ALBAMONTI, MARIO J., Norwich; b. 1912; Tufts 1938; Army Air May 29, 1942 Lt., Captain January 11, 1943; Flt. Surg. on Flying Status; Service Terminated September 28, 1945; Duty—School of Aviation Medicine; Egypt; Libya, Tunis, Sicily, and Italy. Awards—Six battle stars, 2 unit citations.

ALBOM, JACK J., West Haven; b. 1912; Columbia 1939; Army Air September 1941, Lt., Captain July 10, 1942; Major August 2, 1943; Service Terminated September 21, 1945; Duty—Panama, Galapagos Island; 6th Air Force Caribbean; Ft. Dix, N. J., Santa Ana, Calif., Plattsburg, N. Y., Flight Surgeon School; School of Tropical Medicine.

ALDWIN, FRANCIS J., Stamford.

ALLEN, GORGE F., Hartford; b. 1908; McGill 1937; Navy—February 1, 1943 Lt. (j.g.); Lt. March 1, 1944; Service Terminated March 22, 1946; Duty—Sub. Base, New London, Deep Sea Diving and Sub. Medical School, Washington, D. C.; Solomons, Md.; Pearl Harbor, T. H.; USS Gilmer.

ALLEN, JOHN C., New Haven; b. 1914; Hahnemann 1939; Army Air—January 21, 1943 Lt.; Captain September 24, 1943; Service Terminated August 24, 1945; Duty—Miami, Fla.; Drew Field, Fla.

ALLEY, RALPH D., New Haven; b. 1918; Yale 1943; Navy—January 10, 1944 Lt. (j.g.); Lt. July 1945; Service Termniated May 15, 1946; Duty—St. Albans, N. Y.; USS L.S.T. 292; Southampton, England; Exeter, England; USS Lake Champlain; Newport, R. I.

ALPERT, MAX, Bridgeport; b. 1904; Yale 1928; Army—January 8, 1941 Lt., Captain August 7, 1941, Major, September 30, 1942; Service Terminated October 29, 1945; Duty—Ft. Devens, Mass.; Iceland; England; France; Awards—Rhineland battle star.

AMOS, ISADORE L., Danbury; b. 1903; McGill 1926; Army—August 13, 1942 Captain, Major February 13, 1946; Service Terminated April 20, 1946; Duty—Carlisle Barracks, Pa.; Camp Campbell, Ky.; Ft. Lewis, Wash.; Adderbury, England; Camp Twenty Grand, France; First Gen. Hosp., Paris, France; 167th Gen. Hosp., Marseilles, France; Camp Seibert, Ala.; Lovell General Hosp., Ft. Devens, Mass.

ANDERSON, CLIFTON W., Greenwich.

ANDREWS, EGBERT M., Hartford; b. 1904; Harvard 1930; Army—August 11, 1942, Major; Lt. Col. September 16, 1943, Col. January 31, 1946; Service Terminated April 26, 1946; Duty—Drew Field, Fla.; Palm Springs, Calif.; 81st Gen. Hosp., (European Theatre of Operations); Colorado Springs, Colo.; Award—Bronze star.

ANDRUS, OLIVER B., Devon; b. 1903; New York University 1932; Army—November 3, 1942 Captain; Major November 12, 1945; Service Terminated December 25, 1945; Duty—Ft. Slocum, N. Y.; Camp Kilmer, N. J.; Camp Shanks, N. Y.; European-African-Middle-Eastern Theatre of Operations; Camp Stoneman, Calif.

ANSELL, HARVEY B., Jewett City; b. 1908; Tufts 1932; P.H.S. (Coast Guard) July 5, 1943 Lt., Lt. Cmdr. October 1944; Service Terminated April 12, 1946; Duty—Whitehorse, Alaska; U. S. Coast Guard, St. Garibaldi, Ore.; District Coast Guard Office, Seattle, Wash. Removed to Massachusetts.

ANTELL, MAXWELL J., Bridgeport.

ANTON, MICHAEL C., Stratford; b. 1912; Marquette 1939; Army—September 16, 1940 Lt., Captain February 1942; Major March 1945; Retired from service August, 1946; Duty—Ft. Terry, N. Y.; 41st Inf. Div. (Asiatic-Pacific Theatre of Operations); School of Tropical Medicine; Award—Bronze star.

APPELL, HAROLD S., West Haven; b. 1902; Tufts 1927; Navy—July 24, 1944 Lt. Cmdr.; Servcie Terminated October 27, 1944; Duty—Newport, R. I.

APTER, HARRY, Hartford.

APUZZO, ANTHONY A., Bridgeport.

ARNOLD, H. BRUNO, New Haven; b. 1902, Yale 1926; Navy—October 30, 1940 Lt. Comdr., Comdr. August 1, 1942, Captain March 10, 1945; Service Terminated March 17, 1946; Duty—USS Solace; U.S.N.H., Brooklyn, N. Y.; Head of Physical Medicine Section, Rehabilitation Branch, Bureau of Medicine & Surgery, Washington, D. C.

ARRICK, MYRON S., New Haven; b. 1917; Long Island Coll. of Medicine 1943; Army—April 9, 1946 Lt., Captain May 1, 1947; (Still on active duty) Duty—School of Aviation Medici Randolph Field, Tex.; Ft. Sam Houst Tex.; Murphy Gen. Hosp., Waltha Mass.; Letterman Gen. Hosp., San Fra cisco, Calif.

ASHCROFT, ALLAN D., Stratford; 1907; Columbia 1935; Navy—Janu 1944 Lt.; Service Terminated May 1946; Duty—Marine Corps Invasions Guam and Iwo Jima; Reg. Surgeon Marines; Awards — Presidential U Citation.

AYRES, PAYSON B., Cos Cob; b. 19 Toronto 1932; Navy—June 30, 1943 Comdr., Comdr. November 8, 19 Service Terminated March 18, 19 Duty—Camp Elliot, S. D.; Solom Islands; (Asiatic-Pacific Theatre of Op ations); Mil. Govt. School, Colum Univ., N. Y.; Mil. Govt. School, Prin ton, N. J.; Fort Ord, Calif.; Chief M Section, Naval Tech. Mission to Jap Brooklyn, N. Y.

BACKHUS, LOUIS C., Waterbury; 1906; Syracuse 1933; Navy—April 1944 Lt.; Service Terminated April 1946; Duty—Sub. Base, New Lond Conn.; Chelsea Naval Hosp., Bost Mass.; USS Burleson; USS Barnett; Pe Harbor, T. H.; USS Edgecomb; U Dorothea L. Dix; Asiatic-Pacific Thea of Operations; Award—One battle st

BADER, GEORGE B., Washingt Depot.

BAKER, CONRAD S., Willimantic; 1909; Yale 1934; Army—March 13, 19 Captain; Service Terminated Decem 15, 1945; Duty—Ft. Benjamin Harris Ind.; Louisville, Ky.; 25th General Ho (European Theatre of Operation Awards—3 battle stars.

BAKER, PHILIP G., Winsted; b. 19 Vermont 1933; Army—May 19, 1944 Captain September, 1945; Service Ter nated August 16, 1946; Duty—Contin tal United States.

BAKUNIN, MAURICE I., Bridgeport.

BALLETTO, VINCENT, East Haven; 1908; Tufts 1933; Army—September 1943 Lt., Captain January 16, 1945; Se ice Terminated March 20, 1946; Duty Carlisle Barracks, Pa.; Camp Grant, I Camp Seibert, Ala.; Third Army, Eu pean Theatre of Operations; Awards— battle stars, Meritorious Service Plaq for Unit Citation.

NNON, FREDERICK M., Stamford; 905; Vermont 1928; Navy—June 28, 3 Lt. Comdr., Comdr. November 1, 5; Service Terminated May 14, 1946; y—St. Albans, L. I., N. Y.; Camp lford, Va., Norfolk, Va., Annapolis,

PTIST, VINCENT, Terryville; b. 4; Boston University 1942; Army— 16, 1943 Lt., Captain March 1945; ice Terminated August 29, 1946; y—Carlisle Barracks, Pa.; Richmond ny Air Base, Va.; 283rd Regmt., 66th ision (European Theatre of Operas); Lawson General Hospital, Ata, Ga.; Award—Medical combat ge.

RALD, FRED C., New Haven; b.); Boston University 1936; Army —November 4, 1940 Lt., Captain ember 22, 1941; Service Terminated uary 4, 1946; Duty—Ft. Devens, s.; Antilles Air Task Force, Carri; McDill Field, Fla.; Greenville, S. C.

RBER, RICHARD R., Stamford; b. 5; Vermont 1930; Army—May 8, 2 Captain; Service Terminated April 1946 Major; Duty—Newport, R. I.; p Edwards, Mass.; Camp Pickett, Invasions Guam, Leyte, Okinawa; th and 218th General Hospitals, olulu, T. H.; School of Tropical licine; Awards—Asiatic-Pacific Rib- battle stars; Philippine Liberation bon w/1 battle star; Purple Heart.

RBOUR, JR., CHARLES M., Hartl; b. 1910; McGill 1938; Army— uary 12, 1943 Lt., Captain June 1944; vice Terminated December 31, 1945; y—Brooke General Hos., Ft. Sam ston, Tex.; 79th General Hospital— th General Hospital, 1st Auxiliary up; Field Hospitals of the 7th ny—France, Alsace-Lorrane, Ger- ny (European Theatre of Operas); McGuire Gen. Hosp., Richmond, ; Award—Letter of Commendation.

RBOUR, PAUL H., Farmington; b. 4; Yale 1941; Army—August 28, 2 Lt., Captain January 1, 1944, Major ember 26, 1945; Service Terminated rch 9, 1946; Duty—Ft. DuPont, Del.; opean Theatre of Operations.

RNEY, WALTER E., Milford; b. 5; Yale 1935; Army—September 24, 3 Captain, Major April 1946; Service minated August 2, 1946; Duty—Asiatic-Pacific Theatre of Operations; Award—Meritorius Service Unit Pacque.

BARON, SHIRLEY H., New London (Removed).

BASKIN, ABRAHAM; Elmwood.

BASSIN, ALEXANDER L., New Haven; b. 1903; Rochester 1930—Navy—March 1, 1943 Lt. Comdr., Comdr. November 1, 1945; Service Terminated March 1, 1946; Duty—St. Albans, L. I., N. Y.; U. S. Navy 804, Dunkeswell, Devon, England; Fleet Hosp. #115, Guam.

BATES, DAVID H., Putnam; b. 1912; Long Island College of Medicine 1939; Navy—May 20, 1942 Lt. (j.g.), Lt. March 1, 1943, Lt. Comdr., October 3, 1945; Service Terminated November 25, 1945; Duty—USS Plunkett; (North Atlantic), Carribbean and Mediterranean Campaigns; Sicily; Salerno; Mayo Clinic; Hunters Point, San Froncisco, Calif.; Fleet Marine Force, 3rd Marine Division-Guam, Iwo Jima (Asiatic-Pacific Theatre of Operations).

BAUSCH, CARL P., Hartford; b. 1903; Tufts 1929; Navy—June 9, 1943 Lt. Comdr., Comdr. November 1945; Service Terminated April 23, 1946; Duty—Brooklyn, N. Y.; Sampson, N. Y.; Base Hospital #18, Naval Operating Base 926-Guam, (Asiatic-Pacific Theatre of Operations).

BAYNE-JONES, STANHOPE, New Haven; b. 1888; Johns Hopkins 1914; Army—February 11, 1942 Lt. Colonel, Colonel August 28, 1942, Brigadier General February 25, 1944; Service Terminated May 16, 1946—Duty—Deputy Chief, Preventive Medicine Service and Administrator, Army Epidemiological Board, Office of the Surgeon General, Washington, D. C.; England, Egypt; Director of U.S.A. Typhus Commission; Awards—Distinguished Service Medal; U.S.A. Typhus Commission Medal; Army Commendation Ribbon; Honorary Commander, Order of the British Empire;—World War I—silver star w/2 oak leaf clusters; Military Cross (British); French Croix de Guerre w/star; Victory Medal w/4 battle stars. (Removed to New York.)

BEAMAN, GEORGE B., Stamford; b. 1905; Harvard 1934; Army Air—July 11, 1942 Captain; Major November 23, 1943; Service Terminated December 12, 1945; Duty—Jefferson Barracks, Mo.; Santa Ana, Calif.; Bowman Fld, Ky.; Buckley Fld, Colo.; Atlanta, Ga.; St. Petersburg, Fla.

BEARDSLEY, LEWIS G., Newington; (Entered service from Washington, D. C.) b. 1888; Yale 1917; Army—February 10, 1944 Colonel; Service Terminated November 9, 1945; Duty—Manager, Veterans Hospital, Washington, D. C.

BEARG, PHILIP A., New Haven; b. 1913; Yale 1937; P.H.S.—July 15, 1943 PA Surg.(R); Service Terminated April 15, 1945; Duty—California State Department of Health, Vallejo, San Luis Obispo, Calif. (Removed to California.)

BEAUCHEMIN, JOSEPH A., Middletown; b. 1899; Montreal 1925; Navy—May 9, 1942 Lt. Comdr., Comdr. January 5, 1944; Service Terminated November 15, 1945; Duty—Bethesda, Md.; Lion One Medical Unit (Overseas); Naval Advanced Base Unit #8 (Overseas); N.A.S. San Diego, Calif.

BECK, EUGENE C., South Norwalk; b. 1900; Yale 1926; Navy—February 15, 1943 Lt. Comdr.; Service Terminated February 24, 1944; Duty—St. Albans, L. I., N. Y.

BECKER, JOSEPH, New London, b. 1905; New York University 1929; Army—November 6, 1942 Captain, Major April 1946; Service Terminated July 28, 1946; Duty—New Orleans, La.; Longview. Tex.; Topeka, Kan.; Ft. Devens, Mass.; Awards—Meritorious Unit Citation.

BELLEW, RAYMOND F., Bridgeport.

BENTON, PHILIP E., Stratford (Removed to Ohio).

BERGENDAHL, HAROLD A., Norwich; b. 1907; Tufts 1933; Army Air—October 28, 1942 Captain; Service Terminated July 10, 1945; Duty—Boca Raton Fld., Fla.; Rapid City, S. D.; England; France; Awards—4 major campaign stars.

BERGER. ALFRED J., Minneapolis, Minn.

BERLOWE, MAX L., New Haven; b. 1907; Long Island College of Medicine 1934; Army—September 26, 1942; Captain; Service Terminated December 3, 1945; Duty—Camp Shelby, Miss.; Desert Center, Ariz.; Castle Cary, England; France, Belgium, Germany (European theatre of Operations); Awards—Bronze star w/5 battle stars.

BERMAN, BERNARD A., Waterbury; b. 1908; Tufts 1934; Army—January 7, 1941 Lt., Captain 1941, Major 1943, Lt. Col. 1945; Service Terminated January 23, 1946; Duty—Medical Field Service School; Camp Edwards, Mass.; Caribbean Maneuvers; England; Oran; Algiers, Italy, France; Germany, Fort Devens, Mass.; Awards—Bronze star; European-Mediterranean-Near East Theatre Medal w/5 battle stars; Croix de Guerre w/Gold star.

BERNE, ERIC L., Westport; b. 1910; McGill 1935; Army—April 23, 1943 Lt., Captain December 1943; Service Terminated September 1946; Duty—Spokane, Wash.; Fort Ord, Calif.; Brigham, Utah; Ft. Lewis, Wash.

BERNEIKE, ROBERT R., New Haven; b. 1915; Western Reserve 1941; Navy—October 23, 1944 Lt. (j.g.); Service Terminated August 22, 1946; Duty—Norfolk, Va.; Minecraft, Pacific Fleet; Santa Margarita Ranch, Oceanside, Calif.

BERNSTEIN, DWIGHT J., New Britain.

BERNSTEIN, LOUIS, West Hartford; (Entered service from Brooklyn, N. Y.); b. 1908; Berne (Switzerland) 1936; Army—December 23, 1942 Lt., Captain June 3, 1944, Major March 30, 1946; Service Terminated July 15, 1946; Duty—Walter Reed General Hospital, Washington, D. C.; 50th Station Hospital (North African Theatre of Operations); Gardiner General Hospital, Chicago, Ill.; Percy Jones General Hospital, Battle Creek, Mich.

BERWICK, PHILIP, Moodus; (Entered service from Chicago, Illinois); b. 1910; New York University 1938; Army—December 1, 1942 Lt., Captain July 13, 1943; Service Terminated March 15, 1946; Duty—4th Inf. Div. and First Army—European Theatre of Operations; Walter Reed General Hosp., Washington, D. C.; Awards—Unit Citation, 5 battle stars.

BESSER, EDWARD L., Manchester.

BICK, JOHN W., JR., Hartford (Removed).

BIDGOOD, CHARLES Y., Hartford; b. 1897; Virginia 1920; Navy—May 18, 1941 Lt. Comdr., Comdr. August 1, 1942; Captain November, 1945; Service Terminated January 1, 1946; Duty—Guadalcanal; Russell Islands; New Caledonia.

BIEHN, DONALD M., Fairfield; b. 1910; Queens 1937; Army—June 18, 1943 Lt., Captain June 1944; Service Terminated August 9, 1946; Duty—Labrador; Yukon.

BINGHAM, CHARLES T., Hartford; b. 1906; Columbia 1932; Navy—April 19, 1942 Lt., Lt. Comdr. March 1, 1944, Comdr. November 5, 1945; Service Terminated January 22, 1946; Duty—Mobile Hosp., No. 4, Auckland, N. Z.; Base Hosp., #3. New Hebrides; (Asiatic-Pacific Theatre of Operations); U.S.N. Hosp., Philadelphia, Pa.; U.S.N. Hosp., Corona, Calif.

BIONDI, BENEDICT, New Haven; b. 1912; Tufts 1938; Army—August 13, 1943 Lt., Captain March 13, 1944; Service Terminated December 26, 1945; Duty—Carlisle Barracks, Pa.; Camp Grant, Ill.; Camp Ellis, Ill.; North Africa; China-Burma-India Theatre of Operations; Awards—Asiatic-Pacific Ribbon w/3 stars; Chinese Grand Star of Honor; China War Memorial Badge and Medal.

BIRD, FREDERICK S., Bristol; b. 1908; Vermont 1933; Army—September 21, 1942 Lt., Captain February 22, 1944; Major December 15, 1945; Service Terminated March 1, 1946; Duty—Camp Robinson, Ark.; Pacific Theatre of Operations; Awards—Asiatic-Pacific Ribbon w/2 battle stars; Philippine Liberation Ribbon w/1 battle star.

BIRGE, HENRY L., Hartford; b. 1908, Pennsylvania 1933; Army Air—October 1, 1942 Captain Major; Service Terminated February 18, 1946; Duty—Continental United States.

BIRNBAUM, HYMAN B., Madison.

BIRNEY, THOMAS P., Bridgeport.

BISHOP, COURTNEY C., New Haven; b. 1905; Yale 1930; Army—July 6, 1942 Major, Lt. Col. December 31, 1944; Service Terminated November 1, 1945; Duty—Ft. George G. Meade, Md.; Camp Edwards, Mass.; Camp Stoneman, Calif.; 39th General Hospital—Auckland, N. Z.; Saipan; (Asiatic-Pacific Theatre of Operations); Award—Bronze star.

BIZZOZERO, ORPHEUS J., Waterbury; b. 1903; Vermont 1927; Army—October 5, 1942 Major, Lt. Col. May 27, 1944; Service Terminated September 23, 1945; Duty—Walter Reed General Hosp., Washington, D. C.; Deshon General Hospital, Butler, Pa.; North Africa; Sicily; Naples; Rome; Milano (North African-Mediterranean Theatre of Operations); Awards—Legion of Merit; U[illegible] Citation w/5 battle stars.

BLAINE, GRAHAM B.. South K[illegible] (Entered service from New York, N.Y.; b. 1918; Columbia 1943; Army—Octo[illegible] 6, 1944 Lt., Captain December 28, 19[illegible]; Service Terminated November 12, 19[illegible]; Duty—Camp Stewart. Ga.; Carlisle I[illegible] racks, Pa.; Camp Gordon, Ga.; Ca[illegible] Shelby, Miss.; Fort Ord. Calif.; N[illegible] York City; Award—Army Commen[illegible] tion Ribbon.

BLINKOFF, JACK J., Torrington.

BLOOM, DAVID I., Thompsonville; [illegible] 1909; Tufts 1935; Navy—September [illegible] 1942 Lt., Lt. Comdr. July 1945; Ser[illegible] Terminated November 26, 1945; Dut[illegible] Bethesda, Md. U. S. Naval Med. Cen[illegible] Newport, R. I.; Philippine Islan[illegible] European-Pacific Theatres of Operatio[illegible] Invasions of Southern France and I[illegible] guayen Gulf.

BLOOMBERG, MAXWELL H., Wa[illegible] bury; b. 1899; Tufts 1924; Army—A[illegible] ust 8, 1942 Lt. Colonel; Service Ter[illegible] nated June 19, 1946; Duty—Walter R[illegible] General Hospital, Washington, D. [illegible]; Camp Rucker, Ala.; England-Fra[illegible] (European Theatre of Operatio[illegible]; Okinawa (Asiatic-Pacific Theatre [illegible] Operations).

BLUMENTHAL, EDWARD J., [illegible] sonia; b. 1907; Long Island College [illegible] Medicine 1932; Army—June 4, 1932 [illegible] Captain May 16, 1944; Service Ter[illegible] nated January 25, 1946; Duty—Ch[illegible] Burma-India Theatre of Operatio[illegible]; Awrdas—Asiatic-Pacific Ribbon [illegible] battle stars.

BOBROW. AARON, Hartford; b. 19[illegible] Berne (Switzerland) 1936; P.H.S. ([illegible] C.G.)—November 17, 1942 Lt. (j.[illegible] Lt. May 20, 1944, Lt. Comdr. Decem[illegible] 3, 1945; Service Terminated March [illegible] 1946; Duty—Boston, Mass.; Provide[illegible] R. I.; USS General W. H. Gordon; C[illegible] Guard Stations, New York Area.

BODIE, WILLIAM J., New Haven; [illegible] 1897; Georgetown 1929; Army—Aug[illegible] 24, 1942; Captain, Major Februray [illegible], 1944; Service Terminated October [illegible], 1945; Duty—Boston, Mass.; Greenla[illegible]; Walter Reed General Hospital, W[illegible] ington, D. C.; School of Tropical M[illegible] cine; England; Scotland, Norma[illegible] (European Theatre of Operatio[illegible]; Awards—Personal citation; Bronze s[illegible]

ittle stars; Army Commendation Rib- and Citation.

GUNIECKI. STANLEY J., Meriden; 914; Harvard 1940; Navy—July 15, l Lt. (j.g.), Lt. June 1942, Lt. Comdr. ch 1944; Comdr. December 1945; ice Terminated December 15, 1945; y—Quantico, Va.; British Guiana; sacola, Fla.; Marine Air Wing-South ific; Squantum; Awards—Pre-Pearl bor Ribbon w/battle star; Asiatic- fic Theatre Ribbon w/4 battle stars; sidential Unit Citation; American atre w/battle star.

NNER, ROBERT ALEXANDER, JR.. terbury; b. 1912; Maryland 1938; .S. (U.S.C.G.)—August 16, 1943 Lt. .), Lt. October 1944; Service Termi- d July 9, 1946; Duty—Boston, Mass.; ; Beaufort; Argentia, New Found- l; New Orleans, La.; New York City.

RNEMANN, CARL, Canaan.

WEN. FRANCIS D. T., Hartford; b. 6; Maryland 1942; Army—February 1944 Lt., Captain November, 1944; vice Terminated May 10, 1946; Duty I. S. Veterans Administration—Con- ntal United States.

WEN, JOSEPSH J., Waterbury; b. 6; Maryland 1941; Army—July 1, 2 Lt., Captain October 4, 1943, Major ruary 8, 1946; Service Terminated il 26, 1946; Duty—Camp Butner, N. School of Tropical Medicine; North ican-Mediterranean Theatres of Oper- ns; Member Malaria Control Detach- nt #2655; U. S. Typhus Commission, les, Italy; Malaria Control on Corsica Sardinia; Lovell General Hospital, ss.; Awards—2 combat stars.

YARSKY, HARRY M., Wallingford; 1904; Tufts 1931; Army—February 1941 Captain; Service Terminated gust 28, 1941; Duty—Camp Blanding, ; Carlisle Barracks, Pa.; Walter Reed neral Hospital, Washington, D. C.

YD, ROBERT B., Wallingford (En- d service from Providence, R. I.); b. 5; Tufts 1941; Army—October 31, 2 Lt., Captain June 1943, Major cember 1945; Service Terminated rch 15, 1946; Duty—Camp Pickett, ; Camp Miles Standish, Mass.; Euro- n Theatre of Operations.

ACKIN, JOHN T., Hartford (Re- ved).

BRADLEY, E. TREMAIN, New Canaan; b. 1909; Cornell 1936; Army—May 20, 1944 Lt., Captain August 29, 1945; Service Terminated September 1946; Duty—Carlisle Barracks, Pa.; Cushing General Hospital, Framingham, Mass.

BRECK, CHARLES A., Wallingford; b. 1904; Yale 1930; Army—July 15, 1942 Major; Service Terminated May 1, 1945; Duty—39th General Hospital—South Pacific Theatre of Operations.

BREWER, TIMOTHY F., Hartford.

BREWSTER, WILLIAM B., JR., Hartford; b. 1916; Harvard 1942; Army—August 13, 1943 Lt., Captain December 1945; Service Terminated June 10, 1946; Duty—Carlisle Barracks, Pa.; School of Anesthesiology, Philadelphia, Pa.; Brooke General Hospital, Ft. Sam Houston, Tex.; 110th Evacuation Hospital—137th Evacuation Hospital—189th General Hospital—124th General Hospital (European Theatre of Operations); Awards—4 battle stars.

BRIER, HYMAN D., Bridgeport; b. 1908; New York University 1934; Army—August 27, 1942 Lt., Captain March 1943; Service Terminated May 17, 1946; Duty—2nd Amphibian Brigade, Asiatic-Pacific Theatre of Operations; Award—Medical Combat Badge.

BROWN, PATRICK N., South Meriden; b. 1917; Hahnemann 1943; Army—October 7, 1944 Lt., Captain May 1946; Service Terminated October 7, 1946; Duty—Ashford General Hospital, White Sulphur Springs, W. Va.; Carlisle Barracks, Pa.; Camp Joseph J. Robinson, Ark.; Glennan General Hospital, Okmulgee, Okla.; Camp Hood, Tex.; Oahu, T. H. (Asiatic-Pacific Theatre of Operations).

BROWN, RICHARD J., Stratford; b. 1919; Maryland 1944; Army—July 7, 1945 Lt., Captain October 8, 1946; Service Terminated July 6, 1947; Duty—Carlisle Barracks, Pa.; School of Neuropsychiatry; Ft. Knox, Ky.

BROWN, WARREN T., New Haven; b. 1907; Texas 1933; Army—April 1, 1942 Captain, Major February 1943, Lt. Colonel March 1945; Service Terminated February 28, 1946; Duty—Army Medical Center, Washington, D. C.; 39th General Hospital; 369th Station Hospital—Asiatic-Pacific Theatre of Operations; Award—Bronze star; (Removed to Texas).

BRUCKNER, WILLIAM J., New Haven; b. 1909; Cornell 1933; Army—June 1942 Captain; Service Terminated October 1943; Duty—Camp Lee, Va.; Camp Edwards, Mass.; Camp Stoneman, Calif.; 39th General Hospital; Auckland, N. Z. (Asiatic-Pacific Theatre of Operations).

BRUNO, JOSEPH J., New Haven; b. 1907; Hahnemann 1935; Army—May 1, 1941 Lt., Captain September 7, 1942; Service Terminated January 16, 1946; Duty—Camp Edwards, Mass., American Division—Australia, New Caledonia, Guadalcanal—(Asiatic-Pacific Theatre of Operations); White Sulphur Springs, W. Va.; Ft. Harrison, Ind.

BUCCHERI, FRANCIS S., New Britain; b. 1909; Tufts 1935; Army—August 10, 1942 Lt., Captain March 8, 1943; Service Terminated November 11, 1945; Duty—Tunisia; Rhineland; Rome-Arno Campaign; Invasion of Southern France—European Theatre of Operations; Awards—Citation from Commanding General, Mediterranean Base Section.

BUCHAN, RONALD F., New Haven (Entered service from Montreal, Canada); b. 1915; McGill 1942; P.H.S.—July 1, 1943 Asst. Surgeon, Passed Asst. Surgeon December 1944; Service Terminated March 15, 1946; Duty—U. S. Marine Hospital, Staten Island, N. Y.; National Institute of Health, Bethesda, Md.; District #1 Headquarters Office, New York City; Bureau of Industrial Hygiene, Connecticut State Department of Health.

BUCK, BURDETTE J., Hartford; b. 1898; Harvard 1926; Army—August 21, 1942 Major, Lt. Colonel November 26, 1945; Service Terminated February 4, 1946; Duty—Ft. Custer; 37th Field Hospital—British New Guinea, Dutch New Guinea, Luzon, P. I.; Negros, P. I., Panay, P. I. (Asiatic-Pacific Theatre of Operations); Award—Bronze star.

BUCKHOUT, GEORGE A., Bridgeport; b. 1903; Tufts 1935; Army—November 24, 1942 Captain; Service Terminated October 29, 1945; Duty—Camp Pickett, Va.; Fort Jackson, S. C.; Camp Rucker, Ala.; European Theatre of Operations.

BUCKLEY, JOHN L., Torrington.

BUCKLEY, JOHN W., Bridgeport; b. 1906; Georgetown 1933; P.H.S.—July 15, 1943 Sr. Asst. Surgeon; Service Terminated January 6, 1945; Duty—Texas State Department of Health.

BUCKLEY, WILLARD E., Middletown; b. 1907; Boston University 1933; Army—July 15, 1942 Captain; Service Terminated January 14, 1946; Duty—North Africa, Sicily; Italy, France, Germany; Awards—7 battle stars; Bronze Arrowhead.

BUMSTEAD, JOHN H., New Haven; b. 1897; Johns Hopkins 1923; Army—July 1, 1942 Major, Lt. Colonel April 1945; Service Terminated January 30, 1946; Duty—39th General Hospital, Camp Edwards, Mass.; Auckland, N. Z.; Saipan; M. I. (Asiatic-Pacific Theatre of Operations); Award—Bronze star.

BURACK, JASON O., South Norwalk; b. 1913; Tufts 1939; Army—August 3, 1944 Lt.; Service Terminated October 18, 1945; Duty—78th Division-European Theatre of Operations.

BURKE, FRANCIS H., Rockville.

BURKE, JOSEPH F., Waterbury; b. 1905; Yale 1931; Navy—February 14, 1944 Lt. Cmdr., Comdr. November 5, 1945; Servcie Terminated April 15, 1946; Duty—Sub. Base, New London, Conn.; USS Cecil; Iwo Jima; Okinawa; Newport, R. I.; Tokyo, Japan.

BURNESS, SIDNEY H., Hartford; b. 1911; Vermont 1938; Army Air—June 12, 1941 Lt., Captain February 1, 1942, Major October 28, 1942, Lt. Colonel March 18, 1944; Service Terminated January 22, 1946; Duty—Flight Surgeon —Grenier Fld, N. H.; Randolph Fld., Tex.; Dow Fld., Me.; Mitchell Fld., L. I.; Dover; Miami, Fla.; Cuba, Trinidad;— 1st Bomber Command; Award—Bronze star.

CACACE, VINCENT A., Bridgeport; b. 1913; Loyola 1939; Navy—October 26, 1943 Lt. (j.g.), Lt. January 1, 1945; Service Terminated April 15, 1946; Duty —Brooklyn, N. Y.; Base Hospital #2— Scotland; Base Hospital, Cherbourg, France; Award—1 battle star.

CALEF, BENSION, Elmwood.

CALHOUN, HAZEN A., Higganum; b. 1906; Tufts 1934; Army—October 7, 1942 Lt., Captain December 24, 1943; Service Terminated November 15, 1945; Duty—Ft. Hamilton, N. Y.; 703 Medical Hospital Ship Platoon; 222nd Hospital Ship.

CAMPBELL, SHERBURNE, Wallingford; b. 1899; Vermont 1923; Navy—December 7, 1942 Lt. Comdr., Comdr. July 1945; Service Terminated January 5, 1946; Duty—Washington, D. C.; Philadelphia, Pa.; Aeia Naval Hospital, Pearl Harbor, T. H.; Newport, R. I.

CANEY, WILBUR H., Watertown.

CANFIELD, NORTON, New Haven; b. 1903, Michigan 1929; Army—November 28, 1942 Lt. Colonel, Colonel January 15, 1945; Service Terminated May 20, 1946; Duty—Army Medical College; Hq., European Theatre of Operations; Office of the Surgeon General, Washington, D. C.; Awards—Legion of Merit; European-African Ribbon w/1 battle star; Medaille de la Reconnaissance.

CAPLAN, HENRY, Meriden.

CARBONE, WILLIAM C., Hamden; b. 1910; Georgetown 1933; Army—October 22, 1943 Lt., Captain September 1, 1944; Service Terminated December 5, 1945; Duty—Cavalry Battalion Surgeon—U.S. A.—European Theatre of Operations; Awards—Purple Heart; Bronze star.

CARDONE, MICHAEL J., Bridgeport; b. 1913; Vermont 1937; Army Air— September 1942 Lt., Captain August 1943; Service Terminated December 30, 1945; Duty—Africa; Sardinia; Italy; France; Germany; Awards—Bronze star w/4 battle stars.

CAREY, THOMAS B., Clinton; b. 1912; Albany 1944; Army—July 7, 1945 Lt., Captain September 1946; Service Terminated July 6, 1947; Duty—Ft. Knox, Ky.; School of Neuropsychiatry, Bellevue Hospital, N. Y.

CAREY, WILLIAM C., Meriden; b. 1908; Columbia 1933; Army—June 20, 1942 Lt., Captain February 1943, Major February 1944; Service Terminated October 17, 1945; Duty—Camp Forrest, Tenn.; Camp Phillips, Kan.; C.A.M.A. Arizona and California; Ft. Dix, N. J.; Northern France; Ardennes, Rhineland, Central Germany (European Theatre of Operations); Awards—Bronze star w/ cluster, Purple Heart; Medical Combat Badge.

CARLSON, ROBERT I., New Haven; b. 1915; Yale 1939; Army—July 8, 1944 Lt., Captain June 1, 1945, Major October 15, 1946; Service Terminated May 8, 1947; Duty—Carlisle Barracks, Pa.; Memphis, Tenn.; 226th General Hospital, 239th General Hospital (European Theatre of Operations); Ft. Dix, N. J.; Awards—European Theatre Ribbon w battle star; Unit Citation.

CARPENTIERI, ANTHONY L., Wat bury; b. 1912; New York Medical C lege 1938; Army—October 1, 1940 Captain December 1941; Service Ter nated October 1, 1945; Duty—Ft. H. Wright, N. Y.; Camp Devens, Ma Pine Camp, N. Y.; Camp Pickett, V 45th Infantry Division (Europ Theatre of Operations); Awards—Bro star, Bronze Arrowhead, 6 battle stars

CARTER, GRAY, Greenwich; b. 19 Johns Hopkins 1928; Army—July 1942 Major, Lt. Colonel August 8, 19 Service Terminated October 25, 19 Duty—39th General Hospital—Au land, N. Z.; Saipan, M. I.; 204th Gene Hospital, Guam (Asiatic-Pacific Thea of Operations).

CARVEY, EDWARD V., Wethersfie b. 1906; Yale 1935; Navy—July 4, 1 Lt., Lt. Comdr. October 3, 1945; Serv Terminated March 2, 1946; Duty—Pa Island, S. C.; Penarth, Wales; Office the Port Director, N. Y. C.; Samar, P

CASE, EDWARD P., West Hartford.

CASERTA, SILVIO J., Bridgeport; 1911; Georgetown 1937; Army—Octo 1940 Lt., Captain June 1942, Major A 1944; Service Terminated October 19 Duty—Fort H. G. Wright, N. Y.; Wa burn Island, Mass.; Southwest Pac Awards—2 Bronze stars.

CASHMAN, JUSTIN L., North Hav

CASTALDO, LOUIS F., Bridgeport; 1911; Tufts 1937; Army—April 15, 1 Lt., Captain Feb. 1, 1942; Service Ter nated September 26, 1945; Duty—Ft. G. Wright, N. Y.; Ft. Sam Houst Tex.; England; France; Germany; I gium (European Theatre of Op tions); Awards—5 battle stars.

CASTIGLIONE, FRANK M., N Haven.

CAVALIERE, VINCENT J., Bridgep b. 1916; New York University 19 Army—January 14, 1944 Lt., Capt February 15, 1945; Service Termina September 15, 1946; Duty—Carlisle B racks, Pa.; Kennedy General Hospi Memphis, Tenn.; Camp Barkeley, T 176th General Hospital—France; 31 Med. Bn., 90th Division (Europ Theatre of Operations); Award Bronze star; Purple Heart; 3 battle st

LENTANO, LUCA E. H., New ven; b. 1900; Hahnemann 1930; Navy November 15, 1943 Lt. Comdr., ndr. November 5, 1945; Service Ter- ated May 12, 1946; Duty—Navy d Disp., Washington, D. C., Naval n Factory, Washington, D. C.

NCI, VINCENT P., Hartford; b. 1903; ts 1929; Navy—May 8, 1943 Lt. ndr., Comdr. November 1, 1945; vice Terminated February 26, 1946; y—Norfolk, Va.; Spartanburg, S. C.; West, Fla.; Camp LeJeune, N. C.; ıp Pendleton, Calif.; Pearl Harbor, H.; Iwo Jima (Asiatic-Pacific Theatre Operations); St. Albans, N. Y.

NTRONE, PATRICK A., New Haven; 909; Tufts 1935; Army—December 1940 Lt., Captain March 1943; Serv- Terminated October 5, 1945; Duty— ıp Edwards, Mass.; Ft. Devens, Mass.; ave, Calif.; Camp Hahn; Pasco, sh.

RONE, LUKE J., New Haven; b. 7; Bologna (Italy) 1938; Army— ber 7, 1942 Lt., Captain September 1943; Major June 17, 1946; Service minated August 12, 1946; Duty— ıp Blanding, Fla.; Camp Campbell, Ft. Benning, Ga.; Camp Gordon, Camp Gordon Johnston, Fla.; Cush- General Hospital, Framingham, Mass.

AIT, SIDNEY A., Torrington; b. 5; Nebraska 1940; Army—December 1941 Lt., Captain November 28, 1942; ice Terminated February 22, 1946; y—Carlisle Barracks, Pa.; Edgewood enal, Md.; Coast Artillery—Eastern ense Command; Award—Certificate Merit.

ASNOFF, JOHN A., West Haven; b. 0; Long Island College of Medicine 6; Army—April 24, 1943 Lt., Captain ruary 4, 1944; Service Terminated uary 18, 1945; Duty—Memphis, n.; Army X-ray School; Fletcher eral Hospital.

AUCER, NORTON G., Stamford; tered service from Santa Barbara, f.); b. 1916; Columbia 1941; Navy— 15, 1942 Lt. (j.g.), Lt. 1943, Lt. ndr. 1945; Service Terminated June 946; Duty—San Juan, P. R.; Wash- on, D. C., Portsmouth, Va.; Corvallis, gon.

ENEY, CHARLES B., New Haven; 912; Yale 1941; Army—August 25, 2 Lt., Captain April 10, 1943; Service Terminated January 23, 1946; Duty— Camp Edwards, Mass.; Camp Butner, N. C.; Ft. Bragg, N. C.; Solomons; Philippines; Japan (Asiatic-Pacific Theatre of Operations); Awards—Bronze Arrowhead (Lingayen Gulf); Asiatic-Pacific Theatre Ribbon w/1 star; Philippine Liberation Ribbon w/1 star.

CHESTER, LEWIS, New Britain; b. 1912; Vermont 1938; Army Air—June 24, 1941 Lt., Captain June 2, 1942; Service Terminated September 27, 1945; Duty—Bradley Fld., Conn.; Westover Fld, Mass.

CHIPMAN, SIDNEY, Norwalk; b. 1903; McGill 1928; Army—June 15, 1942 Major; Service Terminated December 1, 1945; Duty—Bradley Fld., Conn.; Camp Barkeley, Tex.; Camp Shelby, Miss.; European Theatre of Operations; Awards —5 campaign stars; (Removed to Louisiana).

CHOBIAN, JOSEPH A., Seymour; b. 1907; Loyola 1933; Army—June 1943 Lt., Captain 1944, Major 1946; Service Terminated June 1, 1946; Duty—28th General Hospital—European Theatre of Operations; Awards—City of Liege Medal; 3 battle stars; Unit Citation.

CICCARELLI, ARMANNO W., Bristol.

CIPRIANO, ANTHONY P., New Haven; b. 1916; Long Island College of Medicine 1941; Army—July 1, 1942 Lt., Captain July 17, 1943; Service Terminated December 27, 1945; Duty—Ft. Devens, Mass.; 16th General Hospital—England, France, Belgium—(European Theatre of Operations); Awards—3 battle stars; Unit Citation.

CLAIBORN, LOUIE N., Hamden; b. 1903; Washington University 1927; Army—July 15, 1942 Major Service Terminated February 4, 1946 (Lt. Colonel); Duty—39th General Hospital, Auckland, N. Z., Saipan, M. I. (Asiatic-Pacific Theatre of Operations); Awards—Certificate of Commendation—Western Pacific Base Command.

CLANCY, JOHN J., Hartford; b. 1910; Yale 1935; Navy—July 1940 Lt. (j.g.); Service Terminated June 1941; Duty—First Marine Aircraft Wing—Continental United States.

CLARK, BLISS B., New Britain; (Entered service from New York City); b. 1908; Cornell 1937; Army—September 21, 1942 Captain, Major December 21, 1943; Lt. Colonel January 3, 1946; Service Terminated January 28, 1946; Duty —Camp Monmouth, N. J.; Camp Meade, Md.; Camp Pickett, Va.; England, France (European Theatre of Operations); Ft. Leonard Wood, Mo.; Awards—Bronze star; 1 campaign star.

CLARK, WILLIAM T., Bridgeport; b. 1906; Queens 1934; Army Air—January 7, 1943 Captain, Major December 19, 1945; Service Terminated March 7, 1946; Duty—159th General Hospital (European Theatre of Operations).

CLARKE, CLEMENT C., New Haven; b. 1904; Yale 1932; Army Air July 11, 1942 Major, Lt. Colonel May 18, 1946; Service Terminated August 18, 1946; Duty—MacDill Fld., Fla.; Tuscaloosa, Ala.; Oahu, T. H., Saipan, M. I.; Tinian, Guam—148th General Hospital (Asiatic-Pacific Theatre of Operations); Award —1 battle star.

CLARKE, WINTHROP I., Meriden; b. 1916; Harvard 1941; Army—January 6, 1944 Lt., Captain 1945; Service Terminated January 6, 1946; Duty—Letterman General Hosp., San Francisco, Calif.; Dibble General Hospital, Menlo Park, Calif.

CLEMENT, DAVID H., New Haven; (Entered service from Buffalo, N. Y.); b. 1909; Harvard 1935; Army—July 15, 1942 Captain, Major November 1945; Service Terminated February 4, 1946; Duty—Ft. Meade, Md.; L.S.T. 355, Salerno Invasion; Naples, Italy; Vittel, France; Dachau, Germany; Paris, France; Award—U. S. Typhus Commission Medal.

CLIMO, SAMUEL, New Haven; b. 1906; Ohio State 1929; Navy—February 1944 Lt., Lt. Comdr. March 1946; Service Terminated June 20, 1947; Duty—Newport, R. I.; USS Barnett (European-Mediterranean-Pacific Theatres of Operations); Long Beach, Calif.; St. Albans, N. Y.

COATES, S. PAUL, Suffield; b. 1905; Maryland 1934; Army Air—October 29, 1942 Captain, Major April 1945; Service Terminated September 16, 1945; Duty —School of Tropical Medicine; School of Aviation Medicine; Flight Surgeon—England and France (European Theatre of Operations); Awards—Presidential Unit Citation; 7 battle stars.

COGLAND, JOHN L., Hartford; b. 1911; Vermont 1934; Army Air—February 23, 1941 Captain, Major 1942, Lt. Colonel

1943; Service Terminated January 14, 1946 (Colonel); Duty—Flight Surgeons School, Randolph Fld., Tex.; Africa, Sicily, Italy—North African-Mediterranean Theatre fo Opertions; Awards—Silver star; Purple Heart; Air Medal w/3 oak leaf clusters; (Removed to Arizona).

COHN, SAMUEL H., Hartford; b. 1908; Boston University 1934; Army—February 25, 1941 Lt., Captain December 1941; Major January 1943; Service Terminated October 15, 1945 (Lt. Colonel); Duty—Camp Polk, La., Desert Training Center, Calif.; Indiantown Gap, Pa.; England, France; Belgium; Germany (European Theatre of Operations); Awards—Purple Heart; Bronze star.

COLBURN, RUSSELL F., Stamford; (Entered service from Syracuse, N. Y.); b. 1912; Vermont 1937; Army Air—June 25, 1941 Lt., Captain August 22, 1941, Major August 18, 1942, Lt. Colonel March 15, 1944; Service Terminated January 19, 1946; Duty—Mitchell Fld., N. Y.; Randolph Fld., Tex.; 10th Fighter Wing; Hamilton Fld., Calif.; 70th Fighter Wing—European Theatre of Operations; Lake Muroc, Calif.

COMBES, J. DERAISMES, Salisbury; (Entered service from Whitestone, N. Y.); b. 1891; Long Island College of Medicine 1917; Army—April 15, 1941 Major, Lt. Colonel November 18, 1945; Service Terminated March 18, 1946; Raritan Arsenal, N. J.; Ft. Hancock, N. J.; Camp Atterbury, Ind.; 228th Station Hosiptal, Sherborne, England; 162nd General Hospital, Blandford, England—European Theatre of Operations.

COMFORT, CHARLES W., Jr., New Haven.

COMSTOCK, EDWARD R., Groton; b. 1908; Tufts 1933; Army—August 27, 1943 Lt., Captain May 15, 1944; Service Terminated March 27, 1946; Duty—Carlisle Barracks, Pa.; Patterson Fld.; European Theatre of Operations; Awards—Service Plaque Citation; 3 battle stars.

CONKLIN, CLIFFORD T., JR., Thomaston; (Entered service from Brandon, Vt.); b. 1914; Vermont 1941; Army—July 1, 1942 Lt., Captain August 23, 1943; Service Terminated February 5, 1946; Duty—Carlisle Barracks, Pa.; Iron Range, Qlds., Australia; Milne Bay, N. G.; Hollandia, Dutch New Guinea; Leyte, P. I.; Luzon, P. I.; Awards—Asiatic-Pacific Ribbon w/5 battle stars.

CONLON, WILLIAM L., Manchester; b. 1910; Jefferson 1936; Navy—March 1943 Lt. (j.g.), Lt. May 1, 1944; Service Terminated April 16, 1946; Duty—Naval Disp., Washington, D. C.; Landing Craft Group, Atlantic Fleet, L.S.T. 74; Red Cross Blood Donors Center, Hartford, Conn.; Navy Yd., Boston, Mass.

CONNER, EDWARD D., Fairfield; b. 1917; Long Island College of Medicine 1943; Army—January 5, 1944 Lt., Captain October 23, 1945; Service Terminated August 26, 1946; Duty—School of Military Neuropsychiatry; Camp Barkley, Tex.; Camp Gordon, Ga.; Camp Roberts, Calif.; Luzon, P. I., Moratai, N. E. I.; (Asiatic-Pacific Theatre of Operations); Awards—Asiatic-Pacific Ribbon w/1 star; Meritorious Unit Citation.

CONNOLLY, JOSEPH P., Stamford; b. 1909; Georgetown 1936; Army—September 5, 1942 Captain, Major April 2, 1943; Service Terminated January 11, 1946; Duty—North Africa; Italy—North African-Mediterranean Theatre of Operations.

CONNORS, EDWIN R., Bridgeport; b. 1904; Boston University 1931; Army—November 14, 1942, Captain; Service Terminated June 14, 1943; Duty—Camp Robinson, Ark.; Army-Navy Hospital, Hot Springs, Ark.

CONTE, MARIO G., New Haven; b. 1910; Royal University of Naples (Italy) 1935; P.H.S. (USCG)—April 24, 1944 S.A. Surgeon; Service Terminated July 28, 1945; Duty—Marine Hosp., N. Y.; Manhattan Barracks, N. Y.; District Medical Office, N. Y.; (Exec. Officer—3rd Naval District); Surgeon, West Hampton Infirmary.

CONWAY, DAVID F., JR., New Haven; b. 1908; Columbia 1937; Army Air—June 2, 1947 Captain, Major June 16, 1943; Lt. Colonel January 7, 1946; Service Terminated February 22, 1946; Duty—Ft. Devens, Mass.; Boston Fighter Wing; Andrews Fld., Washington, D. C.; School of Aviation Medicine.

CORBETT, WILLIAM T., Long Hill; b. 1914; Hahnemann 1942; Navy—July 8, 1942 Lt. (j.g.), Lt. November 1944; Service Terminated March 26, 1946; Duty—Portsmouth, Va., Camp Pe Va.; 17th USNC.B. (Special Asia Pacific Theatre of Operations); Aw —Presidential Unit Citation.

CORNELIO, FRANCIS, J., Winsted 1908; Georgetown 1934; Army—J 30, 1942 Lt., Captain July 10, 1943; S ice Terminated June 3, 1946; Dut Camp Williston, Nev.; South Pac (Asiatic-Pacific Theatre of Operatio Ft. Devens, Mass.

CORRADINO, CHARLES L., N Haven; b. 1904; Tufts 1929; Army—J 5, 1942 Captain; Service Termina October 29, 1942; Duty—Aberdeen P ing Ground, Md.; Walter Reed Gen Hospital, Washington, D. C.

COSHAK, MORRIS, Waterbury; 1913; Boston University 1937; Arm Novmeber 12, 1942 Lt., Captain Janu 1944; Service Terminated December 1945; Duty—Ft. Devens, Mass.; 9 Evacuation Hospital—Southwest Pac and Philippines-Asiatic-Pacific The of Operations.

COUTURE, ARTHUR J., Moosup; 1905; Boston University 1932; Arm October 7, 1942 Captain; Service Ter nated February 13, 1946; Duty—Eu pean Theatre of Operations.

COX, MARCUS, Waterbury.

CRAIGHILL, MARGARET D., Gre wich; b. 1898; Johns Hopkins 19 Army—May 28, 1943 Major, Lt. Colo August 1945; Service Terminated Feb ary 2, 1946; Duty—Office of the S geon General, Washington, D. C.; Eu pean-Middle Eastern, Mediterran Persian Gulf Command, India-Bur China, Australian, Southwest Pac Mid-Pacific Theatres of Operatio Awards—European-African-Middle E ern Campaign Medal w/4 Bronze ba stars; Asiatic-Pacific Campaign Me w/2 Bronze battle stars; Legion of Me (Removed to Topeka, Kansas).

CRAMPTON, CLAIR B., Middleto b. 1907; Yale 1937; Navy—Septem 20, 1943 Lt.; Service Terminated Nov ber 12, 1945; Sub. Base, New Lond Norfolk, Va.; Panama City, Fla.; N Guinea; Philippines (Asiatic-Pac Theatre of Operations).

To be Continued

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Robert J. Cook, New Haven
President-elect, Mrs. Charles W. Goff, *West Hartford*
Vice-President, Mrs. James Douglas Gold, Bridgeport
Recording Secretary, Mrs. F. Erwin Tracy, Middletown
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

Due to the unexpected storm, many of the members of the Board of Directors were snowbound and were unable to attend the board meeting which was held on March 3. Those who arrived by car, train or dog-sled said that it was well worth the effort as the meeting was a very active one. The meeting was held at the New Haven City Medical Library. After luncheon, talks were given by Dr. Joseph H. Howard and Dr. Creighton Barker. As your reporter was among those snowbound, details of this meeting will be given at a later date.

Last minute details are being decided for the annual meeting. It will be held on April 28 at the Brooklawn Country Club, Bridgeport. Registration will be at 12:30 P. M., luncheon promptly at 1:00 P. M., followed by a business meeting. Further plans will be announced at a later date.

An invitation has been sent to Dr. Charles C. Wilson, professor of education and public health at Yale University, to speak at the next board meeting to be held in Hartford. We hope that Dr. Wilson will be able to attend the meeting in his old home town. At the same meeting, Miss Irma Bienusen, director of the survey of child health which has been carried on by the American Academy of Pediatrics, will tell the board of the progress of this project in which we have taken a small part.

We are very happy and proud to announce the following reappointments by the National: Mrs. James R. Miller, Hartford, assistant chairman of Organization and Membership of the Northeastern Region, and Mrs. Dewey Katz, chairman of *Hygeia* for the Northeastern Region.

HARTFORD COUNTY

The Hartford Golf Club will be the scene of the annual meeting of the Woman's Auxiliary to the Hartford County Medical Association. Registration will be at 4:30 P. M., a business meeting at 5:00 and dinner at 7:00 P. M. Dr. Howard W. Haggard of Yale University is to be guest speaker. The Auxiliary feels extremely fortunate in having Dr. Haggard and are looking forward to a very pleasant evening.

It was decided that one package each month for a period of one year be sent overseas to a doctor's family. This is just to say in a minute way that they are in our thoughts.

The welfare committee reported that six home bound children were entertained in Manchester by movies. This is just the beginning, folks.

We are pleased to announce that the rummage sale netted $710.36. This is our first project, which we hope will be an annual one, toward building up our newly formed Memorial Medical Scholarship Fund. Mrs. Ogden and Mrs. Phelps wish to thank the chairmen of committees, workers, members who donated articles so generously for their wonderful cooperation. Also Phyllis Taylor, Heidi Bingham and David Unsworth for their splendid help.

The Legislative Committee has invited the membership to an informal group discussion of the National Health Bills presented to Congress last year. Mrs. G. Gardiner Russell, state chairman on legislation, will lead the discussion.

WINDHAM COUNTY

Mrs. Ralph Gilman of Storrs opened her home for a meeting at which the Taft-Hartley and the Wagner-Murray-Dingell health bills were studied. It was felt that all attending gained much in their understanding of the bills. Those present were Mesdames Ralph Gilman, Naury, Kenneth Kinney, Morton Arnold, Walter Rawson, Edward Ottenheimer, William Mac Shepard and Neil Dayton.

Plans were started for a Health Day to be held in Willimantic, Putnam and Danielson during the month of April. The programs will be announced at a later date.

NEW HAVEN COUNTY

At a meeting of the Meriden committee on nursing recruitment which was held at the home of Mrs. Edward R. Smith. Mrs. J. Alfred Wilson who

is the chairman for New Haven County gave a resumé of the state meeting. Mrs. Creighton Barker, state chairman, and Mrs. H. Freeman Pennington, county president, and representatives of the State Nursing Association as well as Mrs. Wilson attended the meeting at the Bridgeport General Hospital.

Members of the Auxiliary are working in close cooperation with the directors of the nursing schools of the hospitals in the State of Connecticut. In addition, committee members will contact service organizations and women's clubs for speaking dates for furthering the nursing recruitment program.

The director of the Meriden Hospital School of Nursing, Miss Grace C. Nicholson, told the committee that two moving pictures entiled "R. N." and "White Battalion" have been shown to interested students in the local high school. These films are being offered to local groups for presentation in cooperation with the Auxiliary's nursing recruitment program.

Many service organizations have requested the postponement of their recruiting program until early fall because there are no vacancies on their program listings until later in the year.

During the drive at Christmas time for gifts and money for the patients in the State mental institutions, Mrs. Bernard L. Mills of Meriden reported an enthusiastic response from doctors' wives and from interested lay persons. More than 100 gifts were received, packaged and mailed to the county chairman of Volunteer Committee, Mrs. Frederick W. Roberts of Hamden.

Mrs. Robert Jay Cooke, president of the Connecticut Auxiliary, gave a very interesting talk on "The Doctor, His Patient, and the Future," at the Meriden Woman's Club on Tuesday, February 17.

Preceding the meeting at the Woman's Club, Mrs. Cook was guest of honor at a luncheon meeting of the Meriden Chapter of the New Haven County Auxiliary held at the Oyster Bay Restaurant. Mrs. Raymond V. Quinlan, president of the Meriden Chapter, presided at the meeting and appointed Mrs. Joseph F. Misuk as chairman of the nominating committee with Mrs. Stephen Lirot and Mrs. George G. Fox nominated from the floor.

Other local members who attended the luncheon in addition to those mentioned above were: Mrs. J. Alfred Wilson, county chairman of nursing recruitment; Mrs. Arthur A. Tower, Mrs. Lawrence E. Thompson, treasurer of the Meriden Chapter; Mrs. Louis A. Pierson, Mrs. H. Freeman Pennington, president of the county auxiliary; Mrs. I. S. Otis, Mrs. F. N. Otis, Mrs. Joseph F. Misuk, corresponding secretary of the Meriden Chapter; Mrs. Walter Lohrmann, Mrs. Stephen Lirot, Mrs. George G. Fox, corresponding secretary of the county auxiliary; Mrs. Michael J. Conroy, Mrs. Max Caplan, Mrs. Winthrop I. Clarke, Mrs. Sherburne Campbell, Mrs. Stanley J. Boguniecki, Mrs. James S. Van Leuvan and Mrs. S. F. DeRosa.

Mrs. H. Freeman Pennington, president, entertained the members of the Board of Directors of the New Haven County Auxiliary at a luncheon at her home on Tuesday, March 9. The monthly board meeting followed the luncheon at which time Mrs. Edward T. Wakeman of New Haven, chairman of the nominating committee presented the slate of officers for the approval of the board.

In addition to the hostess, those who attended were: Mrs. Arthur H. Morse, Mrs. Lewis C. Foster, Mrs. Barnett P. Freedman, Mrs. Ralph W. Nichols, Mrs. Edward T. Wakeman, and Mrs. Creighton Barker of New Haven; Mrs. Milton L. Jennes, Mrs. Sidney W. Jennes, Mrs. John H. Foster, Mrs. Joseph L. Hetzel of Waterbury; Mrs. John H. Renehan of Ansonia, Mrs. Paul W. Vestal of Woodbridge; Mrs. George G. Fox, Mrs. Raymond V. Quinlan, Mrs. J. Alfred Wilson and Mrs. Edward R. Smith of Meriden.

40 Hour Week For Physicians

The British Medical Journal points out that the 5-day, 40 hour week is an essential plank in the Socialist program. It has even been proposed that the medical day of 24 hours be worked in three 8-hour shifts. Already New Zealand with its 5-day 40 hour week is having difficulty securing medical attendance over weekends. Stanley Turner gives the number of physicians in active practice in England as approximately 50,000. With a day divided into 3 shifts, allowing for the increased demand for physician services, he estimates the total medical personnel required by the British National Health Service Act to be three times the present number in active practice. He figures on this basis that there will be a need for 100,000 more physician than there are available in England today, just one more difficulty apparently unforeseen by Mr. Bevin.

OBITUARIES



John Alexander McCreery, M.D.
1886 - 1948

With the death of John Alexander McCreery on January 31, 1948 Greenwich suffered an irreparable loss. It is all too rare to find a man who combined his professional and personal attainments.

Born in New York sixty-two years ago, he was the son of a physician, Dr. John A. McCreery, and Louise Carrigan McCreery.

He received his A.B. degree from Harvard in 1906 and his M.A. from the same institution in 1907. He was graduated from the College of Physicians and Surgeons, Columbia University, in 1910, and then served on the house staff at Roosevelt Hospital for several years. He then became a member of the staff of Bellevue Hospital where he served until 1917.

In World War I Dr. McCreery was a Captain with a Presbyterian Hospital unit in France and acted in the capacity of director of surgery at General Hospital No. 1 of the British Expeditionary Forces. He was promoted to Major and became director of surgery for General Hospital No. 2 of the American Expeditionary Forces.

From 1920 until 1925 Dr. McCreery was assistant clinical professor of surgery at the College of Physicians and Surgeons of Columbia University.

In 1925 he became director of the First Surgical Division at Bellevue Hospital, a position he held until 1940 when he transferred the majority of his activities to Greenwich.

In Greenwich Dr. McCreery maintained offices for the practice of surgery in addition to his activities as chief of staff of Greenwich Hospital. He also visited his New York office twice weekly as part of his self-imposed duties, and was repeatedly called upon in a consultant capacity both in Greenwich and in New York.

Dr. McCreery was a founder-member of the American Board of Surgery. He was a member of the New York Academy of Medicine and a Fellow of the American Society and the American College of Surgeons. He was president of the New York Surgical Society from 1945 to 1947.

He is survived by his wife, Mrs. Eileen Ravenshaw McCreery, three daughters, Mrs. John Gerster of New York, Miss Lalande McCreery, and Miss Sheila McCreery, a student at Johns Hopkins University. He is also survived by two sisters, Mrs. Ramsey Hoguet and Miss Mary McCreery.

It is difficult to find words to express the sadness and regret of those who have worked with and under Dr. McCreery in the years during which he has been connected with the Greenwich Hospital, as surgeon and chief of staff.

Dr. McCreery's wide experience and calm demeanor have carried confidence and encouragement to those under his care and have also been of enormous value to the Hospital and its staff. His unswerving devotion to duty has won him a unique place in the community as well as in the Greenwich Hospital. We have not yet measured the great loss that has fallen upon us.

Jane Lockwood, M.D.



Benjamin B. Robbins, M.D.

1870 - 1948

On January 9, 1948 Dr. Benjamin B. Robbins, health officer of Bristol, died of cardiac disease. He had been active in his profession up to the time of his death.

Dr. Robbins was best known for his work with the young people of the city, being active in Boy Scout, Boys Club, and Girls Club work. He was a past president of the Hartford County Medical Association and a member of the House of Delegates of the State Society for many years.

Dr. Robbins was born in South Africa, came to the United States as a child, was graduated from the New York University Medical School in 1894, and then settled in Bristol where he practiced for fifty-three years.

A zealous health officer, he gave freely of his time and advice to the citizens and physicians of the community. Although he never indulged in alcohol or tobacco, he believed that either used in moderation promoted good fellowship and sociability.

Dr. Robbins was a kindly man, an excellent practitioner, and a loyal friend.

William R. Hanrahan, M.D.

THE DOCTOR'S OFFICE

William Allen Donnelly, M.D., announces the opening of his office for the practice of otolaryngology with special reference to bronchoesophagology and head and neck surgery at 689 Asylum Avenue, Hartford.

Benjamin B. Finkelstone, M.D., announces the removal of his office for the general practice of medicine to 1854 North Avenue, Bridgeport.

Vincent J. Grillo, M.D., announces the opening of his office for the practice of orthopedic surgery at 466 Orange Street, New Haven. Associated with C. W. Henze, M.D.

John W. Haine, M.D., announces the opening of his office for the practice of medicine at 636 Summer Street, Stamford.

Martin I. Hall, M.D., announces the opening of his office for the practice of medicine at 19 High Street, Bristol.

Sanford W. Harvey, M.D., announces his association with his father, Carl C. Harvey, M.D., for the practice of medicine and surgery at 119 Main Street, Middletown.

Harry H. Hershman, M.D., announces the opening of an office for the practice of medicine, specializing in internal medicine and heart disease, at 122 Maple Street, Bristol.

Edwrad A. Rem, M.D., announces the opening of an office for the practice of medicine at 85 East Avenue, Norwalk.

Hirsh Sulkowitch, M.D., announces the removal of his office for the practice of interal medicine to 75 Whitney Avenue, New Haven.

115,000 Doctors Return Directory Cards

So far, more than 115,000 physicians have returned their directory information cards, supplying data for the new American Medical Directory now being compiled. Those physicians who have received their cards and have not returned them are urged to do so at once. This information is needed for your listing in the 1949 directory.

"PHYSICIANS' INFORMATION SERVICE"

A new service provided for you by your State Medical Society.

Its purpose is to provide hospital reading rooms with current literature concerning social and economic problems which affect the practice of medicine.

Important studies conducted by the Research Council for Economic Security and other responsible agencies will be included in this service.

SPECIAL NOTICES

CONNECTICUT VA MEDICAL SOCIETY

April 1

Nutrition

Dr. Robert Levin, Associate Physician, Veterans Administration Regional Office, Hartford

April 8

Pulmonary Disease Problems.

Dr. Paul Kunkel, Chief of Medicine, VA Hospital, Newington

April 15

Diagnosis and Treatment of Amebiasis

Dr. Sydney Selesnick, Gastro-Enterologist,, VA Hospital, Newington

April 22

Peripheral Vascular Diseases

Dr. Alfred Hurwitz, Chief Surgeon, VA Hospital, Newington

April 29

Folvite and the Treatment of Anemias

Motion Picture

THE INSTITUTE FOR OCCUPATIONAL HEALTH OF THE LONG ISLAND COLLEGE OF MEDICINE

Brooklyn, N. Y.

Announces the presentation of the Fifth Postgraduate Course in Industrial Medicine, April 5 to April 16, 1948.

Morning Demonstrations (10:00 A. M.-12:00 M.) and Afternoon Seminars (2:00-4:00 P. M. and 4:30-6:30 P. M.) providing Intensive Orientation in Industrial Medicine and Related Activities in the Occupational Health Field.

The Course has been arranged primarily for Physicians, but will also be of interest and value to Nurses, Industrial Hygienists, Personnel Workers, Representatives of Management and Labor, and other Professional and Business Groups interested in Health in Relation to Occupation.

Address inquiries to: Department of Preventive Medicine and Community Health, 248 Baltic Street, Brooklyn 2, New York.

TRUDEAU SOCIETY EVENING LECTURES

The American Trudeau Society is presenting four evening meetings in conjunction with the Course in Thoracic Diseases to be held April 5 to 17, 1948, at the Boston Medical Library, 8 Fenway, Boston, Massachusetts. Physicians not registered in the course, medical students, nurses and others who are interested are cordially invited to attend without charge. These meetings will be as follows:

Wednesday, April 7, 8 P. M.

Factors Involved in Dyspnea as it Develops in Pulmonary Disease

Dr. George Wright

Friday, April 9, 8 P. M.

Streptomycin in the Treatment of Tuberculosis—Veterans Administration Experience

Dr. John B. Barnwell

Wednesday, April 14, 8 P. M.

Importance of Establishing the Etiology of a Pulmonary Disease Before Instituting Therapy

Dr. David T. Smith

Friday, April 16, 8 P. M.

BCG Vaccination in all Age Groups

Dr. Sol Roy Rosenthal

AMERICAN CONGRESS OF PHYSICAL MEDICINE

The Spring Session of the Eastern Section of the American Congress of Physical Medicine will meet in Philadelphia, at 2 P. M., on Saturday, April 10, 1948, at the Jefferson Medical College.

There will be a Symposium on the "Effect of Physical Inactivity and of Exercise" in the afternoon and a Round Table discussion on "Low Back Pain and the Sciatic Syndrome" in the evening at the Benjamin Franklin Hotel.

CONNECTICUT PHYSICIANS ART ASSOCIATION

EXHIBIT

To be held at the Spring Meeting of the Connecticut State Medical Society, April 27-28-29. The Hanging Committee will let you know when your Exhibit Pieces should be in Fairfield. Dr. Jack of New Haven has offered his services and, if agreeable to everybody, we will ask Dr. Jack to be Chairman of the Hanging Committee.

DUES

Nine of the seventeen suggested dues of $2. Since we do not know what expenses there will be, I would be willing to go along at $2. If more is needed, I suppose we could all "pitch in."

PRIZES AND JUDGING

I have written to several Publishing Companies—Mosby Lippincott, etc.—and several big Drug Companies, suggest-

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ing that they might be interested in offering prizes in the various media. So far, I have had two favorable responses. I should think any Connecticut Business Concern might be induced to become a Patron of the Arts by offering a prize. If any of you have any ideas along this line, I will be glad to work with you.

QUESTION

Should our judges all be physician artists, or should we ask one of our many Connecticut professional artists to assist in judging?

TREASURER

We will need a treasurer. Who will offer to serve?

ARTISTS DINNER

Shall we pattern after the American Physicians Art Association and have a dinner, or at least a meeting, for our group? Such matters as awarding of prizes, election of officers, future exhibits and entertainment (preferably our own talent) could be considered at such a time. What do you think?

PUBLIC RELATIONS

There is a possibility that our exhibit may be shown to the public at Fairfield, Bridgeport and possibly other places. How many pieces should each member enter—two? three?

Robert J. Hansell, M.D., Greenwich

29TH ANNUAL SESSION AMERICAN COLLEGE OF PHYSICIANS

The 29th Annual Session of the American College of Physicians meets this year in San Francisco, April 19-23. Registration headquarters will be at Civic Auditorium. Also the general sessions, morning lectures, panel discussions, and technical exhibits are scheduled for Civic Auditorium. There will be a concert by the San Francisco Symphony Orchestra Monday evening, April 19. The annual convocation of the College will be held Wednesday evening, April 21. On Thursday afternon, April 22, a special ceremony has been arranged to honor the memory of Robert Louis Stevenson, and the same evening the annual banquet will be held in the Fairmount Hotel.

NEW ENGLAND CONFERENCE OF INDUSTRIAL PHYSICIANS

Annual Meeting, Thursday, May 27
Hotel Bond, Hartford
Morning, Afternoon, and Evening Sessions

The Industrial Health Committee of the State Medical Society is now arranging the conference, with the cooperation of the Connecticut Manufacturers' Association, the Connecticut Safety Society, and the Connecticut State Nurses Association.

The conference will encourage discussions of ways and means to improve the health and safety of industrial workers. Cooperation between industrial physicians, nurses, safety engineers, and their employers will be emphasized.

THE AMERICAN SOCIETY FOR THE STUDY OF STERILITY

The American Society for the Study of Sterility is holding its Fourth Annual National Session on June 21 and 22, 1948, at the Congress Hotel in Chicago. The two-day program will be divided into a special series of panel discussions on male infertility, with papers to be read on female and miscellaneous infertility aspects on the second day.

The chairman this year is Professor Edwin C. Robertson, chairman of the Department of Obstetrics and Gynecology of Queens College, Ontario, Canada.

Additional information may be obtained from the secretary, Dr. John O. Haman, 490 Post Street, San Francisco 2, California.

FIFTIETH ANNIVERSARY CONVENTION OF THE AMERICAN HOSPITAL ASSOCIATION

Atlantic City, New Jersey. Convention headquarters at the Traymore Hotel. Meetings and exhibits at the Atlantic City Convention Hall.

September 20-23, 1948.

"Hospitals—Vital to Better Living."

Because of the special events being scheduled for Sunday afternoon and Monday morning, registrants are urged to arrive at Atlantic City Saturday evening, September 18, or the morning of Sunday, September 19.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held at Chicago, June 17, 1948. Candidates for Fellowship in the College, who would like to take the examinations, should contact the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Fourteenth Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, Illinois, June 17-20, 1948. An interesting scientific program has been arranged for this meeting, and speakers from several other countries are scheduled to appear.

Miracle of Living

The Army has recalled all venereal disease control films that were used during the war and is distributing a new one entitled "The Miracle of Living," which reflects the present program. It reports that as a result of stressing the moral reasons for good conduct, the incidence of venereal disease among American soldiers has had a phenomenal drop. For the Army, as a whole, the decrease amounts to 40 per cent since January 1947; and among soldiers stationed in the United States, the decrease totals more than 50 per cent for the same period of time.

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NATIONAL COLLECTORS NETWORK DIRECTORY

OPPORTUNITIES WITH STATE OF CONNECTICUT

The Personnel Department for the State of Connecticut will be glad to provide any qualified physician interested in an excellent opportunity in the fields of tuberculosis, psychiatry, mental deficiency, geriatrics, or general medicine with additional information upon request. All inquiries treated in strictest confidence. Please write to Glendon A. Scoboria, Personnel Director, State Capitol, Hartford, Connecticut.

OUR NEIGHBORS

Massachusetts

The Massachusetts Division of the American Cancer Society has voted a grant to the Massachusetts General Hospital of approximately $2,500 for a particular purpose. The sum thus appropriated represents the money so generously donated in memory of the late Dr. Robert N. Nye, editor of *The New England Journal of Medicine*. The purpose is to initiate and at least partly support the Robert Nason Nye Memorial Study.

This study, a long desired project of the x-ray department of the Massachusetts General Hospital where Dr. Nye served his internship, is concerned with the evaluation of changes in the peripheral blood correlated with known amounts of exposure to radiation sustained by the employees and staff of the x-ray department. Among other matters to be studied is the incidence of leukemia among such workers.

The study will be under the supervision of Dr. Laurence L. Robbins, roentgenologist of the hospital, with the assistance of Dr. Francis M. Hunter, of the clinical laboratory, and in consultation with Dr. John G. Trump of the Massachusetts Institute of Technology.

New Jersey

The Cancer Control Committee of the Medical Society of New Jersey has ruled that patients shall be admitted to cancer clinics in New Jersey only after having been screened by their private physician or by a general medical clinic. In all patients admitted the New Jersey physicians believe there should be a reasonable possibility of the existence of cancer as indicated by at least one of the early symptoms or signs. This action is taken in the interest of economy. New Jersey Cancer Society funds have not yet been sufficient to undertake a solution of the tragic social and economic problem of the care of the terminal cancer patient.

New York

Dr. Robert Boggs has been appointed acting dean of the New York Post-Graduate Medical School. He is a graduate of the University of Oregon and McGill University Faculty of Medicine and trained at Peter Bent Brigham Hospital, Boston, and at New York Hospital. In 1933-34 Dr. Boggs was a research fellow at Harvard Medical School.

* * * *

The American College of Radiology believes that the New York Workmen's Compensation Law needs clarification. This law as amended in 1944 provides in part that there shall be no rebating, assigning, or splitting of fees paid for any services rendered under the act. An exception is made in that a reasonable payment, not to exceed 33⅓ per cent of any fee received, may be made by a duly authorized roentgenologist to any hospital furnishing facilities for radiological examination, diagnosis, or treatment. The law also provides for the removal from the list of physicians authorized to render medical care under the act of the name of any physician who shall be found to be violating these provisions. And further, that any person (including a hospital corporation) who aids or attempts to induce a physician to violate the above shall be guilty of a misdemeanor. These provisions, taken as a unit, make improper fee splitting illegal on the part of both the physician who makes the split and the hospital who receives it.

The radiologists call attention to the fact that this law has been uniformly violated throughout the State and that the Workmen's Compensation Board is well aware of this. Hospitals have been demanding and receiving, frequently under contract, not one-third of the fee, but often as much as two-thirds.

Another amendment to the law states that no claim for x-ray service under the law shall be valid or enforceable except by a laboratory or bureau of a voluntary hospital authorized and licensed under the law, or except by a roentgenologist. This amendment permits a hospital to apply for a medical bureau license and then hire a radiologist on a salary basis and collect the fees for compensation x-ray work. No court has yet clarified the bearing this has upon the injunction against a physician assigning fees to a greater extent than 33⅓ per cent, or the legality of a salaried roentgenologist assigning all fees to the employing hospital.

Rhode Island

Arthur H. Ruggles, M.D., for many years superintendent of Butler Hospital, Providence, has resigned. His successor is David G. Wright, M.D.

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A WORD ABOUT TEAMWORK

In almost every phase of American enterprise — civic, health or economic — the term "teamwork" is synonymous with getting things done quickly and efficiently.

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State Division of American Cancer Society

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NEWS
from County Associations

Fairfield

John A. Miller, a member of the medical staff of Greenwich Hospital for more than 20 years, has been appointed chief of staff to fill the vacancy created by the death of John A. McCreery on January 31. At the same time the board of directors appointed Gray Carter as assistant chief of staff. Dr. Miller received his medical degree from Cornell, interned at Bellevue Hospital, and is on the consulting staffs of United Hospital, Port Chester, Stamford, and Norwalk Hospitals, and St. Joseph's Hospital, Stamford.

The physicians of Norwalk have organized to aid in the Norwalk Hospital building fund campaign. The proposed building will provide 65 more beds, bringing the total to 350. The operating rooms and service facilities of the hospital are also said to be inadequate. Harry S. Phillips is chairman of the physicians' committee.

* * * *

The regular monthly meeting of the Bridgeport Medical Society was held at St. Vincent's Hospital in the auditorium on March 3, 1948. A short business meeting opened at 8:30 P. M.

Dr. Irving Akerson turned the meeting over to Dr. Smykowski who in real Smykowski style introduced Sydney P. Schwartz, cardiologist of the Montefiori Hospital, New York City, N. Y. Dr. Schwartz gave a very interesting and instructive paper on the treatment of rheumatic fever. A buffet supper was served after the meeting.

* * * *

The Fairfield County Medical Association will hold its annual meeting at the Stratfield Hotel in Bridgeport on April 13. The business meeting will start promptly at 4:30 P. M. at which time new officers will be elected, applicants for membership voted upon and general business transacted.

The President, J. Grady Booe will give a paper on "The Care of Rectal Fistulae." A social hour will follow at 6:00 P. M. Dinner will be served in the Ball Room at 7:00 P. M.

We are happy to announce that the Honorable Brian McMahon, U. S. Senator from Connecticut, will be our guest speaker. His subject "Peace in Atomic Energy" should be thoroughly enjoyable and instructive.

* * * *

An anonymous group of Greenwich physicians are aiding patients in a Vienna hospital by providing, through the Greenwich Committee for Foreign Relief, drugs, vitamins, and instruments for the use of fellow professional men in the Austrian capital. Mrs. Samuel K. Meek, committee chairman, recently announced that a shipment prepared by the doctor's themselves and sent through the committee has already arrived in Vienna, where a grateful hospital official is utilizing most of it for the care of infants and children. Included in the shipment was a stethoscope, cod liver oil, vitamin drugs, and general drugs.

Thomas J. Bergin, M.D., has retired as health officer of Greenwich and C. Stanley Knapp, M.D., appointed to replace him as acting health officer. Dr. Knapp has been serving as secretary of the Board of Health. Dr. Willys M. Monroe, commissioner of public health of Pittsfield, Mass., has been appointed health officer of Greenwich beginning July 1.

Hartford

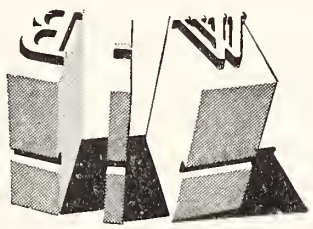
The board of directors of St. Francis Hospital, Hartford, has announced the election of Leopold A. St. John as president of the medical and surgical staff. Other officers elected are George E. Cogan, vice-president; Terence F. McNulty, secretary; Maurice F. Mulville, assistant secretary; and Thomas F. Moylan, treasurer. The executive committee will consist of Timothy F. Brewer, Lewis P. James, George Finley, and Drs. St. John and Cogan, ex officio.

Bernard S. Dignam, plant physician of Bigelow-Sanford Carpet Company in Thompsonville, has been re-elected secretary of the staff of the Mercy Hospital, Springfield, Mass.

Drs. G. W. Heublein, E. W. Godfrey, and L. Bernstein of Hartford have taken over the offices and practice of the late Arthur J. Grant in New Britain. All three are certified by the American Board of Radiology.

Hartford County pharmacists were hosts to over 130 physicians, pharmacists and representatives of pharmaceutical companies at a dinner given at the Hartford Club on January 13. Speakers included

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Dean Hewitt of the College of Pharmacy; Eugene Lamoreaux, director of the bureau of preventive medicine of the State Department of Health; William B. Smith, physician member of the State Joint Conference Committee; and Philip H. Van Itallie, editor of Wyeth, Incorporated's *Pulse of Pharmacy*. This was the second annual Physicians-Pharmacists dinner meeting of Hartford County.

James A. Dolce, M.D., M.S.P.H., chief of the division of local health administration of the Connecticut State Health Department, has resigned his position and is now deputy health commissioner of the Erie County Health Department in New York State. Dr. Dolce assisted Stanley H. Osborn, State health commissioner, in the formation of the health district plans in Connecticut and in the development of the Connecticut Hospital and Public Health Center Survey Report in cooperation with the hospitals and the State Advisory Council.

Albert U. Peacock who has been hospitalized for many months following an automobile accident has resumed his practice as of March 1.

St. Francis Hospital has accepted on its staff William A. Ellis as a thoracic and general surgeon. Dr. Ellis comes to Hartford and the St. Francis Hospital from the Hitchcock clinic in Hanover, N. H., where he was resident and later staff physician. Prior to that he was at St. Francis Hospital as an intern from 1940-1941, in Georgetown from 1941-1942 and for 2 years he was assistant resident at the Baptist Hospital and Bowman-Gray Medical School in Winston-Salem, North Carolina.

At the annual meeting of the staff of the J. B. McCook Memorial Hospital, Hartford, Samuel Donner was elected president, Dillon Reidy, vice-president, and Milton Little, secretary.

Litchfield

Clark K. Peterson of Lakeville has been appointed chief of staff of the Sharon Hospital to fill the vacancy caused by the death of Jerome S. Chaffee. Dr. Peterson, a general practitioner, has been associated with the hospital since 1913. He is a native of Massachusetts, a graduate of Tufts Medical School, and has practiced in Salisbury since 1911.

Middlesex

This issue contains the newsworthy events of the past two months inasmuch as this is a small county and it takes time for news to accumulate.

The Wednesday clinics still under the capable guidance of Christie McLeod are gradually being recognized as a postgraduate method of teaching. She selects a subject with clinical background in our hospital and asks one of the staff members who is qualified to discuss the subject to present it to the staff. This is a decided improvement over the former hit or miss operations of these clinics. The subjects for the past two months have been:

January 7—Bone Tumors—Alfred Sweet

January 21—Medical Case Presentations from Ward Service—William Tate.

January 28—Medical subject—F. Erwin Tracy.

February 2—Carcinoma of Kidney and Bladder—Harry Knight.

February 18—Multiple Sclerosis and Acromegaly Due to Pituitary Disturbance with Case Presentations—Harold Speight.

February 25—Non operative Drainage of the Small Bowel—Harry Frank.

These meetings are being better attended and those who do not attend are being made conscious that they are missing good clinical studies.

Routine matters have been discussed at the monthly medical board meetings. Consideration is being given to intern affiliation with the Rocky Hill Veterans Hospital.

* * * *

The Middlesex Hospital has been forced to raise its rates in keeping with the higher cost of labor and materials. In order to meet a demand for more semi-private beds several of our larger private rooms have been converted to semi-private 2-bed rooms raising our bed capacity to 180. This has helped to relieve the long waiting list for entrance to the hospital and by the physicians cooperating on admissions and discharge a much greater usefulness is being made of the hospital beds.

The Fund Raising Campaign is progressing and plans are being completed in preparation for construction of the new Greater Middlesex Hospital. It is hoped that ground may be broken in the immediate future.

* * * *

The Central Medical Association annual meeting was held on Thursday, February 12, at the Red Coach Inn in Cromwell. This was one of the best attended meetings in a long time. Thirty-five of the members and their wives enjoyed a good dinner and an entertaining after-dinner speaker. The

AN OPEN LETTER TO THE DOCTORS OF CONNECTICUT

Dear Doctor:

Another Convention and another disappointment, for us! We were looking forward to being with you this year, to lend our support to your program, but again, as was the case last year, we could not be accommodated, due to lack of space.

While we have already made application for space for your next meeting, it is not helping the situation for the 1948 Convention. We feel particularly frustrated because your meeting is, virtually, at our front door.

All we can do, therefore, is to invite you to come see us, should you have any leisure time between meetings. We shall take it as an especial favor if you will accept. Free transportation will be provided between Fairfield High School and our store. Telephone 5-3116 and tell us when it will be most convenient for us to call for you.

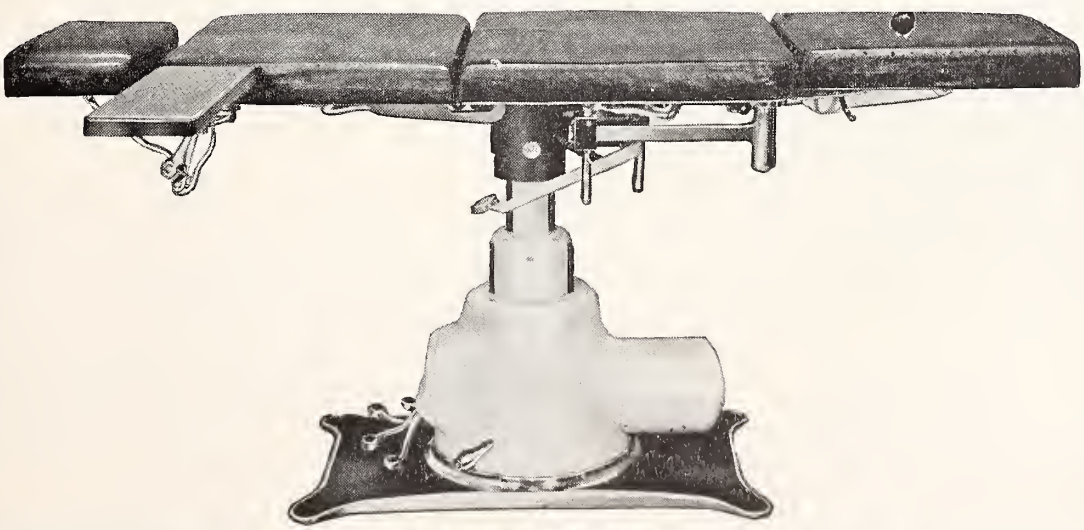
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election of the officers resulted in the unanimous election of Norman Gissler, president; Abraham Rafkind, vice-president; Mario Palmieri, secretary; and Julius Grower, treasurer. The Society has enjoyed a good year and many interesting programs have been presented under the guidance of Clair Crampton.

* * * *

Norman Gardner has traveled to Chicago again in connection with his position as chairman of the Rural Health Committee of the State Society. Norm has gotten to be quite a globe trotter.

Richard Grant has been serving on a committee for an all day meeting to present to the general practitioner methods of diagnosis and treatment of cancer.

Julius Grower, a state delegate of the American Academy of General Practice, conducted an organization meeting of this group and application for a charter was made to the national organization. Plans are being perfected for a statewide meeting and election of state officers of this group.

PERSONALS

William Wrang is recuperating at home from a gastrectomy for ulcer.

Henry Sherwood is enjoying a sojourn in Florida.

"Mike" Craig had a respite from "labor" and enjoyed the New England countryside.

Ben Roccapriore has joined the "Back Brace Gang."

Al DeTora passed out cigars in honor of his second son.

G. Robert Saunders also sired a son.

Norman Gissler became a country squire and is now established in his new home down near the Haddam Jail.

Willard Buckley has found that a driveway in the country can be pretty expensive. In spite of this he enjoys his new home at Miramichi.

M. L. Palmieri has been appointed interim city health officer of Middletown to succeed George B. Davis who has become health officer in Norwalk. Dr. Palmieri came to Middletown as health officer but resigned to enter private practice.

New Haven

George G. Fox of Meriden has been informed of his election as a Fellow of the American Academy of Orthopaedic Surgeons. Dr. Fox received his M.D. degree at Harvard in 1934 and interned at the Meriden Hospital. Following this he received special training in surgery at Long Island College Hospital and in orthopedics at Johns Hopkins and at St. Luke's Hospital in Kansas City.

John C. Allen, dean of the Junior College of Physical Therapy in New Haven, has been named president to succeed the late Harry E. Stewart. Dennis S. O'Connor has been named to the board of trustees.

* * * *

The Ninth Annual Meeting of the Society of University Surgeons was held at New Orleans, January 29, 30, and 31. The meetings were held at the Tulane University School of Medicine and Dr. Alton Ochsner was the host.

The New Haven County members present were: Courtney Bishop, L. N. Claiborn, John C. Mendillo, and Harris B. Shumacker.

Fifty interesting surgical papers were presented and discussed. These will be published in the official journal of this Society, *Surgery*, sometime during the year 1948.

The following honorary members were present: Alfred Blalock, Frank Glenn, senior member; Emile Holman, George Humphreys, member; Rudolph Matas, John J. Morton, Alton Ochsner, and Dallas Phemister. Ninety-five active and senior members were present.

* * * *

On March 3 the New Haven Medical Society was entertained by Dr. Ephram Shore of Cornell University who gave a very interesting talk on his experimental work in shock and in high blood pressure.

On March 5 Alexander Brunschwig, professor of surgery at Memorial Hospital, gave an interesting talk at Strathcona Hall in New Haven on recent advances in pelvic surgery. This lecture was sponsored by the Nu Sigma Nu Fraternity.

* * * *

Bernard Berman, formerly of Waterbury, has opened an office in Waterbury for the practice of ophthalmology. He spent several years in the Service, followed by graduate training in ophthalmology.

Meredith M. Dickinson has opened as office in Waterbury for the practice of general surgery. He graduated from P. & S. in 1938 and has had several years training in general surgery.

The speaker for the March meeting of the Waterbury Medical Society was Dr. Reginald H. Atwater,

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executive secretary of the American Public Health Association. His subject was "The Doctor Looks at Public Health."

The annual dinner of the staff of the Waterbury Hospital was held March 4. There was a large attendance, including the active, attending and intern staffs with a large number of intern alumni present.

News from Yale University School of Medicine

Yale Expands Postgraduate Medical Program

Expansion of Yale facilities for postgraduate education of Connecticut physicians at the School of Medicine has been announced by President Charles Seymour. Dr. William R. Willard, associate professor of public health, has been named assistant dean in charge of Postgraduate Medical Education.

"The appointment of Dr. Willard to advance postgraduate medical education at Yale is in line with the widening scope of teaching and research in the School of Medicine," said President Seymour.

"I am glad that we shall be assisted in establishing the new deanship by funds from the Connecticut State Medical Society which is vitally interested in keeping doctors informed of the latest developments in therapy and public health in many fields.

"This appointment continues the close cooperation between the State Medical Society and Yale which stems back to the earliest origins of the School of Medicine, which was established under the joint auspices of the University and the state society."

Dr. Willard, who is a public health expert and holds degrees in both public health and medicine, will be charged with setting up teaching facilities which do not now exist for Connecticut physicians.

The expanded program will have two aims: 1. Provision for short and long refresher courses to be taken by Connecticut physicians; and 2. Assistance to small Connecticut hospitals in training resident physicians who are preparing to become specialists in various medical disciplines.

At present, Yale and the Connecticut State Medical Society cooperate in postgraduate medical education in three main endeavors—the year round operation of an Institute of Occupational Medicine and Hygiene under Dr. Ronald F. Buchan; cooperation with various state mental institutions by the Department of Psychiatry and Mental Hygiene under Dr. Frederick C. Redlich; and the Clinical Congress of the state society which is held at Yale each fall and attracts from 600 to 800 doctors to its sessions.

This postgraduate activity in the medical school has developed from recommendations by a Yale Committee on Postgraduate Medical Education. Dr. Herbert Thoms, professor of obstetrics and gynecology, is chairman of the committee whose members include: Dr. Creighton Barker, assistant clinical professor of otolaryngology and executive secretary of the Connecticut State Medical Society; Dr. George B. Darling, director of medical affairs; Dr. Milton C. Winternitz, Anthony N. Brady professor of pathology; William U. Gardner, professor of anatomy; Dr. David M. Kydd, associate professor of medicine, and Dean C. N. H. Long, ex officio.

Dr. Willard, who is a native of Seattle, Wash., received his B.S. degree from Yale in 1931 and graduated cum laude from the School of Medicine in 1934. He also received a Doctor of Public Health degree from Yale in 1937. After serving an internship at the Johns Hopkins Hospital, he was an assistant resident at the Strong Memorial Hospital in Rochester, New York and was a Rockefeller Foundation Fellow in Public Health at Yale.

He served as an associate medical economist for the Social Security Board in 1937 when he was made deputy state health officer for Maryland where he remained until January, 1943. He served as a surgeon with the U. S. Public Health Service from January 9, 1943 until September 18, 1944.

In World War II, Dr. Willard served as a major in the U. S. Public Health Service. He attended the School of Military Government at Charlottesville, Va., and the Civil Affairs Training School at Yale.

He served as a malaria control epidemiologist in war areas of the Pacific. After V-J Day, he served with the Bureau of Public Health and Welfare under the U. S. Army Military Government in Korea and was appointed acting director on December 2, 1945. He completed his service with the organization on April 1, 1946 and has been at the Yale Department of Public Health since July 1946.

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NEW BOOKS IN REVIEW

SEXUAL BEHAVIOR IN THE HUMAN MALE. By Alfred C. Kinsey, Professor of Zoology, Indiana University; and *Wardell B. Pomeroy* and *Clyde E. Martin* Research Associates, Indiana University. *Philadelphia and London: W. B. Saunders Company.* 1948. XVI + 804 pp. $6.50.

Reviewed by *Charles W. Stephenson*

Probably never before has a book reviewed in these columns attained the varied publicity that this book has already received within two months of the time it was given to the public. Already numerous reviews have appeared, magazines have printed articles based upon its findings, it has attained the status of "Best Seller" as listed by both the *New York Times* and the *Herald Tribune*, and it has been the subject of a Gallup Poll. No one can say how often it is a topic of conversation in various groups.

Certain it is that the findings presented in this volume will necessitate a very marked revision of the thinking of practically all physicians who are ever confronted with the problem of advising the man who seeks answers to his sexual problems. Many will make every effort to deny the possibility that the given facts are indeed facts. Already your present reviewer has seen reviews so colored with emotion in their approach to a discussion of this book that they obviously were penned by individuals who found material in the book which they were unable to accept; perhaps it was material which recalled past events in their own lives which they wished to keep forever submerged.

But the very surge of popularity of the book indicates that there existed a need for it. Obviously the persons of whom advice was sought, and this includes physicians, were not able or willing to give adequate answers to the questions proponded. The lay individual is seizing upon this volume as a means whereby to attain the solutions he heretofore could not find.

Some lay readers, however, will be much disappointed. Undoubtedly the title (which would be more accurate were it "Sexual Behavior in the *American* Human Male") has attracted many who hope to receive through the reading thereof, a vicarious gratification of their own needs. The format of the book and the matter-of-fact style in which it is wrtiten will prove disappointing to these thwarted souls. Actually it is very monotonous reading. There is tremendous repetition throughout, owing to the fact that the data is reviewed from different points of approach. There are innumerable tables and figures, and while these do provide the thoughtful reader with all he needs to make statistical checks, and do present incidence figures in graphic form, they seem so similar on very superficial glance that they emphasize the feeling of monotony of the book.

Part One, occupying 150 pages, is devoted to the method of obtaining histories; to the precautions taken to preserve the anonymity of those who have contributed their histories; to the innumerable checks and re-checks made to assure the writers that their data was no mere chance deviati due to imperfect sampling; and to a discussion of the sta tical procedures by which the authors have arrived at th conclusions.

Part Two deals with the Factors Affecting Sexual O let. Throughout the book all statistics are based upon orga as the criterion determining sexual activity. Hence there little speculation regarding the psychology of sex, or, that matter, the psychopathology of sex. It occasionally l comes necessary to discuss psychological theories based up previous speculations or upon insufficient data, only to sh that such previously held theories become untenable in light of the present findings. On the other hand, the disc sion of the various sexual behavior patterns obtained different educational and social levels is most illuminati and no little startling. The authors feel very definitely t their findings indicate that the Freudian concept of sublin tion of sexual energy just does not agree with fact, so mu so "as to constitute an academic possibility rather thar demonstrated actuality." Many will be surprised to fi that the data shows that those who mature early not o have the highest incidence of sexual activity (orgasm) l also are the ones whose sexual activity continues longest the highest rates in various age groups. Impotence, as product of sexual excess, "is not justified by such data n available."

Part Three deals with the Sources of Sexual Outlet. will be a very marked surprise to most readers that in 5300 males whose histories provide the basis of this pres book, the incidence of some type of homosexual outlet some time in their lives is 37 per cent of the total. Previ estimates of homosexual incidence made by other work has rarely been higher than 4 per cent of the total popu tion. This low figure seems now untenable.

There are excellent discussions of the conflicts which a between the mores of the people and the legal code rega ing "sex offences." And there occur occasional brief pa graphs relating the facts to the problems of teaching, in tutional management, and to other social implications of overall picture. At no time do the authors become involv in the "right-wrong" question. The morals they do pretend to discuss; they adhere to facts only. But they present ample evidence that the moral code, as most peo like to think of it, is just not in keeping with the act social and/or solitary sexual adjustments of the populat at large. Actually the figures show that if the legal c were fully enforced, "more than 95 per cent of the total m population" would at some time or other in their lives jailed for "sex offences."

Your reviewer believes that the results obtained in very painstaking and meticulous research program of th authors merit very careful reading by every physician w ever expects to give sexual advice to any male pati (Future volumes of the series begun with this book will c with females, and with other aspects of the total problem. should have far wider reading than just the medical pro sion. Every teacher handling adolescents, every judge, l yer, or legislator should have this book as required read Every clergyman, of whatever creed, needs the informat here presented for the first time. And those lay pers

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who have not been able to find satisfactory answers to their problems will, in the meantime, keep right on making this book a "best seller."

DIAGNOSIS IN DAILY PRACTICE. An office routine based on the incidence of various diseases. By Benjamin V. White, M.D., Assistant Clinical Professor of Medicine, Yale University School of Medicine, Consultant in Gastroenterology, Veterans' Administration Hospital, Newington, Conn., Branch Section Chief in Gastroenterology (New England), U. S. Veterans' Administration, Assistant Visiting Physician and Chief of Gastroenterologic Clinic, Hartford Hospital, Hartford, Conn., and *Charles F. Geschickter*, M.D., Professor of Pathology, Georgetown University Medical School, Consultant in Pathology, U. S. Naval Medical School, Bethesda, Md., Consultant in Pathology, Mt. Alto Veterans' Administration Hospital, Washington, D. C., Pathologist-in-chief, Gallinger Municipal Hospital, Washington, D. C. *Philadelphia: J. B. Lippincott Company*. 1947. 693 pp. with 360 illus. $15.

Reviewed by JOHN C. LEONARD

This 693-page volume is an extremely valuable reference book for the general practitioner of medicine. Part One consists of the diagnostic survey and contains very valuable and nicely visualized statistics presented in a manner that is most helpful in the study of disease. The importance of the medical history and the physical examination of the patient is presented in a very usable manner. The psychiatric examination is stressed in its daily importance to the general practitioner. Part Two is devoted to diagnostic abnormalities from the standpoint of symptoms. The importance of disturbance of functional rhythm is stressed. The etiologic history, psychogenic factors in disease and symptoms, as they relate to the various bodily systems, are well presented. Part Three deals with diagnostic abnormalities of disease in physical findings. The meaning of abnormalities found by inspection as well as by implemented examination is stressed in its relation to the entire patient. Part Four deals with the laboratory procedures which can be performed in the physician's office in helping him to arrive at the diagnosis. These are particularly well chosen from the standpoint of simplicity, efficiency and practicability. A small section is devoted to referred diagnostic procedures, which cannot ordinarily be performed in the physician's office. Part Five contains the outline of major diseases and deals with the medical emergencies of shock, acidosis, uremia, respiratory failure, peritoneal irritation, intestinal obstruction and arterial occlusion. The major diseases are then outlined by systems. A particularly valuable section is included at the end of the book showing various efficiently arranged office setups for the physician, along with the equipment



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which he will need in the up-to-date office practice of medicine.

The authors are to be congratulated for their tireless energy, efficiency, and the practical selectivity with which they have combined the ideas and ideals of the pathologist and the clinician into such a splendid volume.

A MANUAL OF PHARMACOLOGY. (Seventh edition.) *By Torald Sollmann,* M.D., Professor Emeritus of Pharmacology and Materia Medica, School of Medicine, Western Reserve University, Cleveland. *W. B. Saunders Company: Philadelphia and London.* 1948 1132 pp. $11.50.

Reviewed by Desmond D. Bonnycastle

In this edition of Sollmann's textbook, in addition to new sections realing with a variety of new compounds such as the antibiotics, folic acid, BAL, antithyroid drugs, antihistaminic drugs, etc., some changes have been made in the presentation of material. The table of contents is essentially the same as in the previous edition but the subject material has been arranged in two columns on a page which makes reading and the search for information easier. The extensive bibliography in this edition covers literature back to 1926, for older references the fifth and sixth editions must be consulted.

This textbook is of great value in reaching an understanding of the mechanisms by which drugs produce their effects, for it not only presents what is believed to be the mode of action of drugs but also many of the controversial points in the theories of drug action. The student and the clinician who wish a greater understanding of the basic principles in pharmacology will find this an excellent reference book as well as a text.

COMMUNAL SICK-CARE IN THE GERMAN GHETTO. By Jacob R. Marcus, PH.D., Adolph S. Ochs Professor of Jewish History, Hebrew Union College. *Cincimati: The Hebrew Union College Press.* 1947. 335 pp. $4.

Reviewed by Samuel Donner

The German Jew of the Middle Ages lived in a community which was in but yet was not a part of the world surrounding it. As such he created and lived in an autonomous social and cultural life which remained almost unchanged until the fall of the Bastille.

Among the institutions which it developed were its own philanthropies. It is the history of these philanthropies which the author attempts to describe in this small volume replete with detail.

The members of these communities felt that the care of the sick and needy was their sacred religious obligation. They hired physicians, some real, some not so real, to care for them and provided quarters for their housing. "hekdesh" was the room or rooms provided by the community for the itinerant or the housing of the poor sick lying in.

From these beginnings developed "Brotherhoods" at intended to care for the above communal obligations, becoming mutual aid societies to benefit the members themselves. From such "hekdeshes" started to care the itinerant and poor sick, grew some of the great hospi of the world, e.g., New York Mount Sinai, Michael R of Chicago, and Cedars of Lebanon of Los Angeles.

The author has put this material together so that reading is not too difficult. This little volume can be rec mended to anyone interested in studying one of the ea methods of approach to the communal recognition of obligations to the poor and needy.

A PRIMER OF CARDIOLOGY. By George E. Bu M.D., F.A.C.P., Associate Professor of Medicine, Tu University School of Medicine, and *Paul Reaser,* M Instructor in Medicine, Tulane University School of M cine. *Philadelphia: Lea & Febiger.* 1947. 272 pp. 203 illustrations. $4.50.

Reviewed by Paul H. Twaddle

The authors of this excellent primer are attempting this presentation to acquaint the medical student and t newly interested in cardiology with a proper correla between clinical problems and physiological principles at onset of their study. It is their belief that thinking in te of physiology will give a clearer insight into the sub matter presented and will also serve as a basis in explai variations which will be encountered in practice. emphasis is enhanced by illustrations of sound traci electrocardiograms, phlebograms and pulse tracings.

The material is concise and is easiily followed. Fig appear on the same page as the subject matter that they intended to illustrate and as a result a number of the fig are reproduced several times. These illustrations are gramatic for the most part. One of these appearing rep edly shows the various elements of the cardiac cycle demonstrates the simultaneous behavior of the diffe valves, carotid pulse, venous pulse, ventricular press electrocardiogram, phonogram and heart sounds. The m rial is dogmatically presented to avoid confusion. Con versial subjects are presented but not discussed. It is ho whenever a question is not fully answered, that the stu will be stimulated to turn to more advanced texts o the current literature for further information.

This book should be found useful by students as as by those interested in understanding the basic princi of cardiology.

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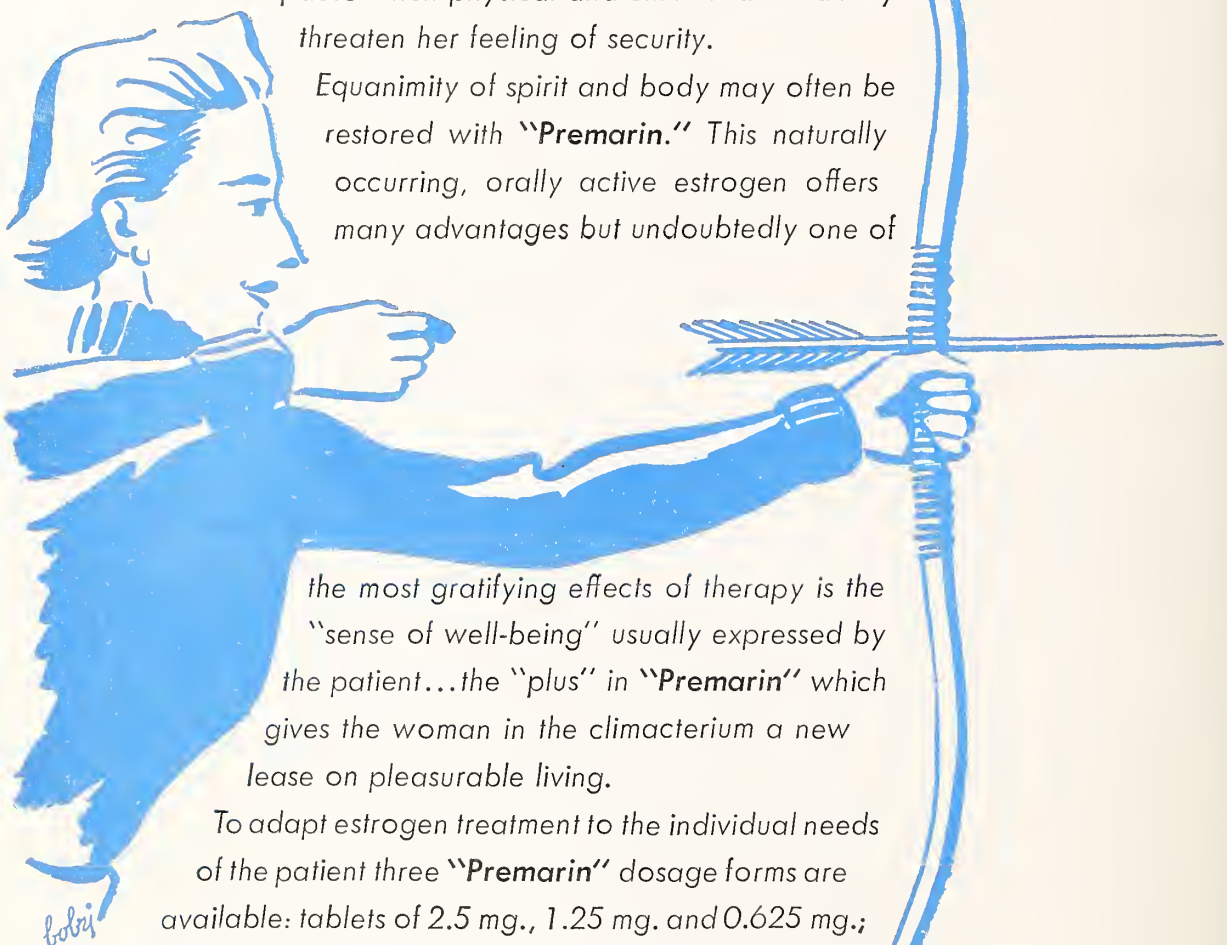
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THE PRESIDENT'S PAGE

It is the custom, as I am reminded by the Editor, for the President of the Society to occupy a page of this estimable journal in each of its issues. This is not only a privilege for which those who seek to assist and beguile us with their wares pay heavily, but also a weighty responsibility in that what is written should be of interest rather than dull, and pertinent while not presumptive. This opportunity would tax the ability of a great essayist were there such today, or of the present commentators in the daily press of whom it might well be said that if they were laid end to end, not only would they encumber a lot of ground but that it would also serve them right.

It is opportune in this first effort that I express to each member of the Society an appreciation of the honor which has been bestowed upon me and this I do most sincerely. More important is the recognition of one of the by-ways of medicine, that of medical education, and the implication of a rapprochement between the School of Medicine and the physicians of Connecticut, an association which at times in the past has been intimate and mutually beneficial.

The changes in the education of the undergraduate student over the past half century have been so great and so consumptive of both time and money that there has been but little opportunity for those involved to consider seriously or undertake a program for the education of the physician once he has received his doctorate of medicine. In the past quarter century it has become recognized that several years of further intensive study and experience are of the greatest importance for the full development of the physician to the point where he can assume the heavy responsibilities incurred in whatever his lifetime activities may be. This period has become in large part the responsibility of the hospital, for in it are the clinical facilities necessary for this phase of graduate education. However, relatively few of these have envisioned the opportunity and the obligation which rests upon them in this matter.

It has long been recognized also that when the physician once engages in practice the passage of time, concomitant with progress in knowledge and skills, is likely to leave him stranded by the wayside. While some may find the means and opportunites for continuing their education throughout their professional life, many do not, for these do not lie readily at hand and the necessity is not always immediately apparent. Stimulation and opportunities to learn are the requisites for this continuing or postgraduate education of the physician.

It is for these purposes that the Society and the School of Medicine have entered into a joint project which is being developed at the moment and will shortly begin to make itself felt. Every effort will be made to provide opportunities for continuing the education of the physician which will be stimulating and available to him with the least possible inconvenience. The effectiveness of this will not, however, be entirely dependent upon the excellency of the program, but in considerable part upon the response of the individual members of the Society.

Samuel C. Harvey, M.D.

The
CONNECTICUT STATE MEDICAL JOURNA

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THE DIAGNOSIS OF BRUCELLOSIS

WESLEY W. SPINK, M.D., *Minneapolis*

The Author. *Professor of Medicine, University of Minnesota Medical School; Staff Member, University of Minnesota Hospitals*

IT IS a pleasure to discuss with you a mutual clinical problem. I say mutual problem, because in looking over the reports of the United States Public Health Service for the first three months in 1947, I note that Connecticut has had more cases of brucellosis reported for that period than any other state in New England.[1] There is no doubt that the incidence of human brucellosis is on the increase, at least in some areas in this country. This increase may be related to several factors. In the first place, more and more people are becoming conscious of undulant fever and its meaning because of the dissemination of information of a popular nature. Secondly, physicians in recent years have been more alert in their attempts to diagnose the disease. But probably the most important factor responsible for this increase pertains to the failure to control the reservoir of brucellosis, which is in domestic animals. Prior to World War II many successful attempts were made in various endemic areas in this country to eradicate the disease in domestic animals, particularly in cattle. Then during the war, because of the loss of professional personnel and because of the tremendous demand for food stuffs, these programs had to be curtailed and even abandoned. The result is that we are now witnessing an augmentation of this reservoir of brucellosis, especially in cattle and in swine. This in turn is reflected in an enhancement of the number of human cases.

EPIDEMIOLOGY OF BRUCELLOSIS

I should like to emphasize that the reservoir brucellosis is in domestic animals. It is rare f brucellosis to be transmitted from human to huma There are a few cases on record where an infant h contracted the disease through the ingestion of mi from a mother who has active brucellosis. The have been instances where an *in utero* infection h taken place, but this rarely occurs. Because m acquires brucellosis either directly or indirect from domestic animals, a knowledge of the epiden ology of the disease is of aid in diagnosing it. The are three species of Brucella, which though close related, each have distinguishing biological cha acteristics. *Br. melitensis,* harbored by the goat, considered to be the most invasive species for hum beings. Up until recently, infections due to *B. melitensis* were regarded as occurring relatively i frequently in this country, but human cases melitensis infections have been encountered in Iow and Minnesota, and the reservoir in these two Stat is not in the goat, but rather in the hog.[2,3] Th natural reservoir for *Br. suis* is swine, and m acquires an infection from this species as a result contact with infected porcine tissues. Howeve milk-borne human infections due to *Br. suis* i vading cattle have been recorded in recent years.[4] The natural habitat of *Br. abortus* is the uterus an udder of cattle, and this species causes the majorit of human infections in Minnesota. The disea caused by *Br. abortus* is transmitted to human bein as a result of contact with infected tissues or bod fluids, or following the ingestion of contaminate cow's milk.

Presented at the 22nd Connecticut Clinical Congress, Yale University, September 19, 1947

The presentation was accompanied by lantern slides, and represented investigations on brucellosis carried out under grant by the U. S. Public Health Service

It is apparent that brucellosis is an occupational disease occurring in packing plant employees, livestock producers, farmers, veterinarians and in laboratory workers. On the other hand, the disease is frequently contracted through the ingestion of unpasteurized milk or milk products.

CLINICAL FEATURES

The clinical picture of brucellosis is seen with monotonous regularity. The acute phase may be expressed in typhoid-like fashion, that is, chills and fever without localizing signs. More frequently, acute brucellosis mimics influenza. In fact, time and time again, patients have been seen who have stated that they had an acute illness diagnosed as influenza, but from which they have not recovered. Serological and bacteriological studies carried out in these individuals have revealed the presence of brucellosis as the cause of their protracted debility. The symptomatology of both acute and chronic brucellosis may be briefly considered together. The outstanding subjective manifestation of this disease is weakness. It is invariably present and, if absent in the list of the patients' complaints, the diagnosis of brucellosis should be doubted. Other prominent features are sweats, generalized body aches and headaches. Back pain is a major complaint not infrequently, and should always suggest the presence of spondylitis. Brucellosis commonly induces nervousness, emotional instability and mental depression. We have had two cases of suicide in our series of brucellosis. Painful joints may ensue during the course of brucellosis, but we have never seen an instance of progressive arthritis. Abdominal pain and diarrhea are present more often during the acute phase of the illness.

As far as the physical findings are concerned, brucellosis is a disease where there is a multiplicity of complaints with few or no localizing findings. The two most constant abnormal signs are peripheral lymphadenopathy, occurring in about 50 per cent of the cases, and splenomegaly, detected in approximately a third of our patients. Hepatomegaly is demonstrated frequently. Tenderness over the spine is occasionally found, and, as already stated, may represent a destructive process in one or more of the vertebral bodies. Significant eruptions of the skin are rarely seen.

Some of the complications of brucellosis that have been seen in our clinic are four cases of subacute bacterial endocarditis, two cases of encephalomeningitis, seven cases of spondylitis and one instance each of pleuritis, pleural effusion, pericholecystic abscess. We have never seen as a complication, orchitis or epidydimitis in a male, nor have we observed an instance of human abortion due to brucellosis.

As a result of clinical observations made in our clinic over a period of 10 years, it may be concluded that the duration of active disease in the majority of patients contracting brucellosis is of short duration, namely, less than three months. Occasionally exacerbations occur, or a chronic type of illness takes place which may last for months, and in some cases, for years. The detection of the chronic case is not simple and can only be made with any degree of certainty with the aid of laboratory procedures.

DIAGNOSTIC PROCEDURES

Leukocyte count. Though not specific, the total leukocyte and differential counts are helpful in the diagnosis of brucellosis. A normal count or a tendency toward leukopenia is the most usual finding. In only one instance have we seen the total leukocyte count above 10,000 cells per cubic millimeter. There is usually present a relative or absolute elevation in the lymphocytes. In a patient acutely ill with a febrile illness, these hematological findings may be of assistance in the differential diagnosis of brucellosis. In our experience such data have aided in ruling out other systemic pyogenic infections.

Erythrocyte sedimentation rate. Early in our clinical studies we were impressed by finding normal sedimentation rates in patients with brucellosis, including those with suppurative complications. If consistently normal values occurred in a large series of patients with proved brucellosis, such information would also be helpful in distinguishing the disease from other pyogenic infections. An analysis of several hundred determinations performed in patients with both acute and chronic brucellosis has shown quite clearly that the sedimentation rate may be normal or accelerated, and is of little significance in differentiating brucellosis from other diseases. In the individual case the sedimentation rate is of some aid in following the clinical course of the disease. It has been observed that in patients having acute or chronic brucellosis with an accelerated sedimentation rate, improvement in the condition of the patients is associated with a return of the sedimentation rate to normal values, whereas those

who continue to exhibit a chronic state of ill health also manifest persistently rapid sedimentation rates. An analogous picture occurs in patients with active pulmonary tuberculosis.

Agglutination test. The most reliable laboratory procedure for screening suspected cases of brucellosis is the agglutination reaction. In our own laboratory we have had more reliable results with the method which utilizes falling dilutions of serum in tubes than with the rapid slide agglutination technique. We have never seen a bacteriologically proved cases of brucellosis without demonstrable agglutinins in the serum. The higher the titer of agglutinins, the more likely one will isolate organisms from the blood. Active brucellosis is usually associated with titers of 1 to 100 and greater. Although there are reports stating that positive blood cultures for Brucella have been associated with the absence of agglutinins in the serum, this has never been observed in our clinic. We do not deny that such a dissociation may occur, especially in the early phases of the disease. The success of the agglutination test is dependent upon the technique employed in carrying out the test and also upon the antigen that is used. During the past few years we have had the most consistent results with the antigen of *Br. abortus* developed by the U. S. Bureau of Animal Industry. I might point out that on several occasions my associates and I have observed a case of brucellosis and a laboratory report has indicated the absence of agglutinins in the serum of that patient. Then, serum that has been obtained from such an individual has been divided into two parts and each sent to one of two laboratories. In more than one instance a high titer of agglutinins has been reported by one laboratory, and absent agglutinins or a low titer has been the finding of the other.

Complement fixation test. This procedure has been abandoned in our laboratory since the results correlate quite well with the agglutination test and the latter is easier to perform.

Cultural techniques. In every patient where serious consideration is being given to the diagnosis of brucellosis, a culture of venous blood for Brucella should be undertaken. While the isolation of Brucella from human patients requires experience and patience, such data are of incontestable diagnostic help. The organisms are not obtained with regularity even from the blood of undoubted cases of active brucellosis. In our own laboratory when specimens of blood are cultured immediately after they a obtained from the patients, Brucella are isolat from less than one-fourth of the active cases. dependable culture medium is tryptose phospha broth (Difco) to which has been added 1 per ce sodium citrate. A 10 per cent tension of carb dioxide is necessary for the growth of *Br. abort* More recently we have been using the double me of Castaneda[6] for isolating Brucella from specime of blood, and have found this improvement to highly satisfactory.

Brucella tend to localize in tissues and organs the body containing a large amount of reticuloend thelial cells, such as the lymph nodes, bone marro liver and spleen. In human cases of brucellos where cultures of venous blood have remain sterile, bone marrow in the sternum has been asp ated and cultured for Brucella. In three instanc Brucella have been recovered from aspirated sterr marrow when simultaneous cultures of venous blo remained sterile. In two cases Brucella have be isolated from cerebrospinal fluid, following injecti of the fluid into fertilized chick eggs. Except in o instance, we have been unsuccessful in obtainin Brucella from cultures of urine. Thus far we ha been unable to isolate Brucella from human bile.

Opsonocytophagic test. This procedure involv the quantitative phagocytosis of viable Brucella ce by polymorphonuclear leukocytes. In general, br cellosis in its initial stages reveals feeble phag cytosis of Brucella by the leukocytes, and as t patients recover, phagocytosis becomes quite pr nounced. However, as a diagnostic procedure f doubtful and sporadic chronic cases of brucellos we have found the test to be unreliable. The opson cytophagic test is not being used in our clinic at t present time for diagnostic purposes.

Intradermal tests with Brucella antigens. One the characteristic features of brucellosis is the d velopment of a state of tissue hypersensitivity Brucella cells as determined with intradermal test The usual procedure is to quantitate the degree hypersensitivity with either heat-killed bacteri cells or some other antigen such as brucellergen These antigens give a delayed tuberculin-like typ of reaction. As far as is known, the demonstratio of a positive reaction is specific for Brucella, that i it means that at some time in the past the tissu have been sensitized by Brucella antigen, presumabl viable organisms. However, a positive skin test do not mean active infection. Likewise a negative te

does not imply the absence of a Brucella infection. We have observed negative tests in patients severely ill with brucellosis, including those with subacute bacterial endocarditis due to *Br. abortus*.[8,9]

It has become apparent to us that in a patient who is acutely ill with a high titer of agglutinins and a history of exposure to brucellosis, it is not necessary or desirable to perform an intradermal test for brucellosis. Most clinicians utilize the skin test in the chronically ill patient having an ill defined group of symptoms, and for whom no satisfactory explanation of this illness is available. Such a patient may give no history of exposure to the disease; possess no abnormal physical findings; and no agglutinins for Brucella may be demonstrable in his serum, or, if present, in a titer less than 1 to 100 dilution. In an endemic area such as Minnesota we have been very reluctant to make a diagnosis of chronic brucellosis under these circumstances. In the first place, one is left with the problem as to what shall be done with the patient if such a diagnosis is made, and in the second place, the suggestion of brucellosis to the patient may plunge him into further despair since he has been informed by others that there is no satisfactory cure for the disease.

One cannot escape the impression that the chronicity of brucellosis and the state of ill health exhibited by suspected cases may be related to the state of tissue hypersensitivity to Brucella antigen. Therefore, it is not unreasonable to attempt desensitization of the unfortunate patient with Brucella antigen. Many physicians have attributed improvement in chronic brucellosis as a result of such therapy. It is not proposed to discuss the therapy of brucellosis at this time, but simply to point out that the skin test for brucellosis and its interpretation is the subject of much controversy. Furthermore, we do not want to draw any conclusions relative to the results of desensitization, except to state that in our own experience many individuals have been labelled as having chronic brucellosis on the basis of vague symptoms, especially weakness and fatigue, and a positive skin test, and then have been treated week in and week out with some preparation of Brucella antigen. Discouraged and depleted of funds, they have sought further advice, and only on rare occasions has the diagnosis of active brucellosis been seriously considered by our group. A diagnosis of chronic brucellosis has been the haven for many a psychoneurotic. On the other hand we have found few cases of proved brucellosis mislabelled as neurasthenics or psychoneurotics.

This discussion of the skin test in brucellosis can only be concluded by stating that a physician must be extremely cautious in the interpretation of a positive reaction, especially when ancillary laboratory data for the disease are lacking.

SUMMARY AND CONCLUSIONS

There are indications that the incidence of human brucellosis is on the increase. The correct diagnosis of the disease is made by correlating many factors such as the epidemiology of brucellosis; the vague clinical course; and the judicious interpretation of diagnostic procedures. The most reliable laboratory aid is the demonstration of Brucella in cultures of blood. Even under the best of circumstances, positive cultures are obtained only in the minority of active cases. The next most reliable test is the agglutination reaction. The opsonocytophagic index is of little specific value. Extreme caution is necessary in interpreting the results of a positive intradermal reaction.

BIBLIOGRAPHY

1. Public Health Reports, 62:892, June 13, 1947.
2. Jordan, C. F., and Borts, I. H.: Ocurrence of *Brucella Melitensis* in Iowa, J.A.M.A., 130:72, 1946.
3. Kabler, P., Bauer, H., and Nelson, C. B.: Human Brucella Melitensis Infections in Minnesota with Hogs as the Probable Source, Jr. Lab. and Clin. Med., 32:854, 1947.
4. Beattie, C. P., and Rice, R. M.: Undulant Fever due to Brucella of the Porcine Type—*Brucella Suis*. Report of a Milk Borne Epidemic, J.A.M.A., 102:1670, 1934.
5. Borts, I. H., Harris, D. M., Joynt, M. F., Jennings, J. R., and Jordan, C. F.: A Milk Born Epidemic of Brucellosis Caused by the Porcine Type of Brucella *(Brucella suit)* in a Raw Milk Supply. J.A.M.A., 121:139, 1943.
6. Castaneda, M. R.: A Practical Method for Routine Blood Cultures in Brucellosis. Proc. Soc. Biol. and Med., 64:115, 1947.
7. Huddleson, I. F.: Brucellosis in Man and Animals. p. 244, New York, The Commonwealth Fund, 1943.
8. Spink, W. W., and Nelson, A. A.: Brucella Endocarditis. Ann. Int. Med., 13:721, 1939.
9. Spink, W. W., Titrud, L. A., and Kabler, P.: A Case of Brucella Endocarditis with Clinical, Bacteriologic and Pathologic Findings. Amer. Jr. Med. Sciences, 203:797, 1942.

FUNDUS CHANGES IN BLOOD DYSCRASIAS

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DURING the routine examination of the fundus oculi in the course of a refraction examination, or because of a complaint of defective vision, the ophthalmologist often observes changes in the retina or choroid which indicate some pathological state which has been transmitted by the blood stream to the retina. To identify these changes is often difficult and requires blood studies and a general physical check-up. However, some of the changes seen by the ophthalmologist are sufficiently characteristic to make possible a diagnosis at once.

The alterations which occur in the fundi in blood discrasias are chiefly hemorrhages, exudates, variations in color of the fundus and of the size and color of the blood vessels. We may also find changes in the optic nerve head, and the end results of the more acute stage in the form of pigmentary deposits and atrophic patches. Exophthalmos occurs in certain of the diseases under consideration.

A large and rather heterogeneous group of diseases is listed under the name of blood dyscrasias, with a relatively large number of etiologic causes and with several forms for which we know no cause. Probably the largest number of blood diseases is found in the anemias, which include pernicious anemia, secondary anemia, chlorosis and the anemia of pregnancy. According to Ottenberg the forms of anemia which the ophthalmologist is most likely to meet are (1) deficiencies, loss of blood, and of iron in the hypochromic form, and the lack of the anti-anemic principle, as in pernicious anemia; (2) injury to blood-forming organs—leukemia, Hodgkin's disease, Niemann-Pick's, Schuller-Christian and Gaucher's disease. Also interference with the regeneration of blood such as diseases of the spleen—Banti's disease.

Let us first consider the question of hemorrhages in the diseases under discussion.

Hemorrhages begin to appear when the red corpuscle count falls below 32 per cent of normal, sa a count of around 2 milion. The escape of bloo from within a vessel implies a defect in the end thelial lining. Probably the most common are th flame shaped hemorrhages and here the extravasate blood lies in the nerve fiber layer or among th ganglion cells. Blood which lies deeper than this usually rounded in form. They are found chiefly i the posterior part of the fundus.

At times hemorrhages are found only after care ful search. These are mostly small and flame-shape or circular in outline, but large ones may be seen an occasionally the retina may be widely infiltrate with blood. These larger hemorrhages result fro escape of blood from the larger vessels and may b several times the size of the nervehead. They occu sometimes from purely physical causes, as in th hemorrhages of the newborn, at other times fro conditions of the blood, such as in pernicious anemi In some cases diseases of the vessel wall, as in dia betes, and perhaps in arteriosclerosis and toxins o poisons in the blood, and even congenital defect are responsible for the bleeding. Some hemorrhage are lozenge-shaped, especially in severe anemia, an may have pale centers. These latter probably ar the last elements of the blood to escape from th vessel wall, namely, fibrin and platelets. Smal wooley-appearing patches sometimes accompan them. So long as hemorrhages are confined withi the limiting membrane they disappear completel and leave no pigmentary deposits or other evidenc of their previous existence.

There are two groups of blood dyscrasias in whic we are likely to find hemorrhages. These are, first acute infectious processes such as a septic bloo stream in which the hemorrhages are due to toxin which weaken the wall of the vessel, or to thrombi and second, the anemias in which the blood platele count drops greatly, reducing the coagulability o the blood.

The fundus color may vary considerably in thes diseases and there may be no correlation betwee the pallor and the degree of anemia. The opalescen

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ize seen in the retina and disc is probably due to dema.

Changes in the retinal vessels—There is rarely a minution in the size of the retinal arteries—unless, course, the disease is complicated by arteriolerosis. More often the vessels are distended, especially the veins. The optic nervehead is frequently ller than normal and this is usually due to the nemia present, but may be due to atrophy resulting from areas of degeneration in the retina.

In *simple anemia* we may see nothing beyond a eneral pallor of the fundus (a condition not to be o lightly diagnosed, since both eyes are affected d there is normally such a wide variation in color the eyegrounds). In addition to the pallor of the ckground the retinal vessels appear to contain uid dilated in color, so that there is less difference an normally between arteries and veins. Very rely a small hemorrhage may be found in simple nemia.

In the *secondary anemias* eyeground changes are sual. These consist in a pallor of the fundus, vessels le but well filled, and the veins even distended. here may be a general haze over the fundus in ie more severe cases. The most conspicuous anges consist in the presence of retinal hemrrhages and they tend to lie close to the disc. They sually do not affect vision preceptibly and they sorb completely. Here occur also the soft edged atches which are of the same appearance as the otton-wool patches of renal retinitis. They are ften associated with hemorrhages in the nerve fiber yer. When hemorrhages and white patches occur gether the picture cannot be told from that of enal retinitis.

Leukemia—There are usually changes in the retina nd choroid, and sometimes in the orbit in leukemia. robably no case of this disease goes on to a fatal ermination that does not show eyeground changes. his holds true for the lymphatic and the myelonous varieties, both acute and chronic in course. he myelogenous type is approximately four times s frequent as the lymphatic. The first abnormality bserved in the eyegrounds is an engorgement of he veins of the retinal circulation—as yet no other hanges are seen. Engorgement of the arteries is less requent, but sometimes both arteries and veins become distended, are paler than normal and are f almost the same color. The appearance of the essels is as if they contained much diluted blood. his is an expression of the anemia and seen in all cases of low blood count. The engorged veins become sacculated and turgid and cut into the arteries. They do not, however, displace the arteries as in arteriosclerosis. Gibson states that these changes in the veins and the presence of hemorrhages are sufficient to make the diagnosis of leukemia. At this stage hemorrhages appear in the retina, but are quite variable, at times difficult to find and at other times quite sizable. They may appear to surround a vessel. While variable in size they are usually small or medium sized, and may be flame-shaped when superficial, round or rosette-shaped if in the deeper layers, or may even burst the external limiting membrane and become subretinal. Pale centers are seen in some of them, probably due to an accumulation of leukocytes at this point. Sorger even described spontaneous hemorrhages in the iris and ciliary body.

The presence of hemorrhages does not necessarily mean a particularly bad prognosis and they may clear up during remissions of the disease. The final stage of leukemia shows a generalized infiltration of the retina and choroid, in addition to the changes described. The color of the fundus varies from pale to a greenish hue. This is the true, characteristic "leukemic retinitis" and it is not seen very frequently. There may be extensive periphlebitic infiltration with white lines as wide as the vein itself. The optic nerve is blurred as a result of edema. Histologically, disorganization and degeneration of the nervefiber layer, with cytoid bodies and varicosities of the nerve fibers are seen. It is these changes, plus the aggregation of white cells which account for the white patches seen. The fundus changes may restrict the field of vision, and deafness is present at times.

Different explanations have been offered to account for the leukocytic infiltrations in the retina, choroid and orbit. Some explain them as due to a diapedesis and localized proliferation, while others believe them due to stimulation and overgrowth of pre-existing lymphoid elements.

Chlorosis is a rapidly disappearing disease, so that most of us have little experience with it. A number of pathologic changes have been reported as occurring in this condition. While papilloedema is often present we must not overlook other causes for the swollen discs. Treatment with iron may clear up the papilloedema. At times a star-shaped figure at the macula is seen and hemorrhages have been recorded. The principal change is pallor of the retina. The swelling of the nervehead, the headaches, and pos-

sibly vomiting, may closely resemble the picture of increased intracranial pressure.

Purpura Hemorrhagica is a serious disease in which spontaneous hemorrhages appear from mucous membranes and also in the retina. The latter are generally in the nervefiber layer about the disc. They are not of any prognostic significance and behave as do other hemorrhages in such conditions as secondary anemia. They are associated with a reduction of blood platelets.

Optic atrophy has been reported as a sequel to thrombocytopenic purpura. Blindness may develop and there may be ecchymotic spots on the lids, slight exophthalmos and limitation of ocular movements. Retinal hemorrhages and complete atrophy of both optic nerves have been seen.

Pernicious Anemia—Retinal hemorrhages are the rule in this disease and always appear before death. They are of the type with pale centers and probably associated with a low platelet count.

Polycythemia—This disease is divided into two groups, primary and secondary. The primary form is designated as erythremia and the secondary as erythrocytosis. In the former there is an excess of red blood cells with increased volume of blood, and, at times, an increase in capillary vessels. In the second type there is polycythemia as a compensatory measure in order to carry an increase of oxygen when this is needed.

Erythremia Vera Rubra—In this disease we have a great inrease of red blood cells, up to 12 to 14 million, and a moderate increase in the white cells. The liver and spleen become enlarged and the patient presents a cyanotic appearance. The marked color change is observed in the eyegrounds which are very dark bluish red. Hemorrhages and exudates are rare, as are changes in the nervehead. There is not only an increase in the volume of blood but the viscosity is raised, thus embarrassing the circulation. The loss of vision is often out of all proportion to the appearance of the fundi. The arteries show little alteration but the veins are engorged. No cause is known for this disease.

Retinal Hemorrhages in the Newborn are not unusual—They have been found in 29 instances among 281 babies. Histological examinations showed hemorrhages in the retina, principally in the inner layers. The hemorrhages probably develop during the process of birth and may be due to pathologic conditions of the blood, permitting escape into the retina, but more likely they are due to the physical strains to which the child is subjected. The hem orrhages are rather large as a rule and appear a thin sheets of blood. Absorption is complete and n residue is left behind.

Cyanosis Retinae—This condition is present i some cases of congenital heart defects and change in the retina are present. Both veins and arteries ar darker than normal and are of about the same colo The anterior ciliary, conjunctival and retinal vein are distended. The arteries may or may not be en gorged. Retinal hemorrhages are uncommon. I both arteries and veins are darker and wider tha normal, a communication between the two sides o the heart is present, but if only the veins are darke and more tortuous some other condition exists which is not due to a mixture of arterial and venou blood. The picture in cyanosis may be confuse with Vaquez's disease, but in the latter hemorrhage may be profuse—never in cyanosis retinae. Th arteries show only slight changes in Vaquez' disease and the veins are not so dark.

Erythremia or Vaquez-Osler Disease is character ized by a high red count, up to 12 million, with n ophthalmoscopic changes seen, but with a low colo index. Fundus changes may be present and visio may be greatly reduced. Those which are observe are engorged retinal veins with hemorrhages, bu normal arteries. The picture may at times be con fused with that of thrombosis of the retinal veins Edema of the optic disc has been recorded. The cause of the disease is not known.

Impaired Vision from Serious Loss of Blood—Following a severe hemorrhage there may occur large effusions of blood into the retina with serious and perhaps permanent, loss of sight. These hemorrhages in the retina rarely occur from traumatic causes, but are more often seen after severe intestinal bleeding, and next in frequency from uterine hemorrhage. Blindness may come on at once or may be delayed for days, and both eyes are not necessarily equally affected. There may be a delay in the appearance of blindness between the two eyes. The visual loss usually follows a sudden loss of blood from the body but has been observed where there was a prolonged drain, such as may occur in hemorrhoids. At first the ophthalmoscope shows edema of this disc, pallor of the vessels, which are of normal diameter, and possibly hemorrhages into the retina. As time goes on the atrophy of the optic nerve increases, and the blood vessels become permanently reduced in size and vision is irreparably blurred.

PRACTICAL APPROACH TO THE PROBLEM OF EPIDEMIC RINGWORM OF THE SCALP

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THE epidemic of scalp ringworm which became apparent early in 1942 is still with us. It was first noted in the large eastern cities but by this time no section of the country seems to have been spared.

Although the recent developments in the local therapy of tinea capitis represents a real advance, it is now become apparent that too many cases unfortunately still need roentgen epilation to effect a cure.

Failings of local therapy are due to the inability of the fungicide to penetrate deeply enough in the hair follicle. X-ray epilation is effective because it eradicates the hair follicles and does away with foci of reinfection which can not be reached in many instances by local applications of fungicides.

It has been agreed by most observers that the Microsporum audouini and the Microsporum lanosum[1,2,3] were responsible for nearly all of the cases of scalp ringworm. A scalp ringworm due to a Microsporum of animal type like M. lanosum is more readily cured by local treatment or manual epilation, and even spontaneous cures may occur. The human type of miscosporum infection like M. audouini is much more resistant to local therapy, and prior to this epidemic it was believed that infection of the scalp due to this organism could only be cured by x-ray epilation plus thorough postradiation treatment in the majority of the cases.

Rothman[4] and his associates have been able to adequately explain the mechanism which is responsible for the spontaneous cure of scalp ringworm in the postpubertal period. From the findings of these authors it is apparent that with the onset of puberty the glands of the scalp start to secrete a substance which contains, in higher concentration than before, low-boiling saturated fatty acids with selective fungistatic and fungicidal action on the M. audouini. The hair fats of adults include acids such as pelargonic acid which is probably formed in greater quantity in the postpuberty period and is mainly responsible for the spontaneous cure. It is significant that even this fatty acid which seems to have a selective action on the scalp fungi does not kill the fungus spores by penetrating the hair, but it prevents reinfection of the new hair following the old infected hairs in process of shedding. As Rothman has pointed out, there are other fatty acids such as triedecanoic which are also found in greater concentration in the adult hair fat and which most likely play a role in the spontaneous cure in the postpuberty period.

War conditions resulting in congested living as well as unsanitary conditions in barber shops, especially through the use of electric clippers, undoubtedly have played an important role in the spread of tinea capitis.

Six times as many boys as girls were infected in the series of cases studied in Hagerstown and this relative proportion seems to hold about true for most of the published statistics. Most of the children affected were under ten years of age. The fact that boys were much more affected than girls in the present epidemic was explained by the fact that the barber shops were the principal sources for the spreading of these infections. Furthermore, it was the use of the electric clippers in hair cutting which was mainly responsible. This was shown by the finding of infected hairs in the clippers; the fact that in the majority of the affected boys it was the clipper areas where the infection was initiated and the very fact that boys were much more often affected than girls because they were the ones that visited the barber shops. Of course there were many other lesser causes for the spread of the epidemic,

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such as school contacts, especially the wearing of common headgear, the use of common brushes and combs in the homes, and a possible but not very probable cause of infection, the plush backs of motion picture seats. The use of common combs and scissors among the girls was responsible for a definite but smaller percentage of the cases.

Fortunately rapid diagnosis of the cases was readily carried out by means of the Woods light. With this instrument a typical fluorescence is produced when the hairs infected with the fungi, mainly responsible for the present epidemic, were exposed to it. This brilliant green fluorescence is easily distinguishable from other types of fluorescence when infected hairs are examined under the Woods light. The rather rare scalp infections which are due to Trichophyton gypseum and Trichophyton violaceum or Trichophyton tonsurans show no fluorescence. Trichophyton Schoenleinii fluoresces a very pale green, if at all. Should there be a suspicion of tinea capitis with a negative or non fluorescing lesion, a direct examination should be made by exposing the suspected hairs to a 10 per cent solution of potassium or sodium hydroxide, or by culture.

It has been impossible because of the large numbers of cases involved in the present epidemic to allow the children to have the benefit of x-ray epilation. While x-ray epilation is admittedly the most effective and most reliable type of treatment, it must be carried out correctly to avoid permanent alopecia. There are also a number of cases, and these are increasing in number, who have recurrences following roentgen epilation. Such recurrences of course may be due to improper post-epilation therapy or inadequate epilation to begin with. It is for this reason and because it was impossible to treat with x-rays the large numbers of cases affected that the Public Health Service has stressed the value of the development of a good reliable local therapeutic regime.

Lane,[5] Carrick,[6] Keeney[7] and others have stated that the use of propionate-propionic acid mixtures brought about cures by local therapeutic measures alone in 30 per cent to 70 per cent of the cases in which it was tried. In the use of the fatty acids the hair was clipped very short and kept that way. The medication was used twice daily. A shampoo was given before the morning application. In most of the cases approximately 60 to 80 treatments were needed to obtain a cure.

Carrick[6] also used undecylenate-undecylenic ac ointment in a carbowax base and found it effecti in approximately 40 per cent to 60 per cent of l cases.

Miller, Lowenfish and Beattie[8] have not found t fatty acids as effective as others but they did rep that they seemed to prevent the spread of t infection to new areas in most patients.

Schwartz[9] still believes that 5 per cent salicyl nilide in carbowax 1500 to which was added cationic detergent Hyamine 1622 and a saturat solution of copper undecylenate in carbowax 15 gave the best results in the cases with which he w familiar. He also stated that pentachlorphenol 1 p cent in carbowax was also efficacious. The "Intr derm TCAP" of MacKee, Herrmann and Cobb has also been reported to be highly effective topical treatment of ringworm of the scalp. The reported 34 per cent of their cases as cured. It to an average of 10 weeks of treatment to cure the cases.

Strickler[11] has recommended the use of an iodi combination with acetic acid and he reported th he was able to cure 64 per cent of his cases by th local therapy.

The author was intimately concerned with t Hagerstown[1] experiment in which there was a intensive study of local therapeutic measures f the treatment of tinea capitis. He agrees th preparations such as the fatty acids and salicyl nilide, etc., are more effective than the old methods recommended for local treatment. It h been his experience, however, that the good resul obtained by the Public Health Service in such large percentage of their cases by local therapeuti measures alone were due to the efficiency of th teams carrying out the local treatment as much to the remedy which was used. In this experimen especially towards the end of the study when th best results were obtained and the highest percen age of cures was seen, the personnel obviously w at peak efficiency. They could readily recogniz even a slight fluorescence as a truly infected hai They insisted that the patient come to the clini daily and be treated by either a physician or trained nurse or volunteer. The schools were s organized that new patients could easily be picke up and, what is more important, manual epilation the infected hairs under the Woods light was prac ticed routinely and continuously until no more i fected hairs were seen. Also, the follow-up syste

very well carried out.

Such a routine with its excellent results is possible when a trained team is present to properly carry out the local therapy. I have found in private practice and in attempting to have private physicians carry out the same treatment under my supervision that local treatment was much less effective than it was while I was conducting the Hagerstown experiment as a part of the Public Health Service team.

Local therapy has not proved as efficacious in private practice because of the lack of time of the physician or the inexpertness of the mother in carrying out the treatment. It is for this reason that I must admit after several years in private practice that a distinction must be made between an attempt to control the epidemic of ringworm of the scalp by the use of Public Health Service personnel and the local Public Health agences, and the treatment of individual cases by the private physician.

The treatment of choice by the private physician is the use of x-ray epilation. Once the epidemic has been checked and the numbers of the cases decrease, x-ray epilation followed by some of the recently developed local therapeutic measures must be resorted to as the treatment of choice. Too much time is lost by the child of school age by the persistence of the physician in continuing local therapeutic measures for too long a period. It is my opinion that if the two or three most valuable local treatments have failed to give an adequate response in sixty days, or a maximum of ninety days, or if during three weeks of intensive local treatment the infection keeps spreading to new areas, we must then consider that either the therapy itself is ineffective or that it is being so inexpertly carried out that it is useless to continue. Since most local health agencies refuse to agree with the Public Health Service that infected children should not be kept out of school, it is best to immediately resort to x-ray therapy in the cases just mentioned in order to avoid further loss of school time by the child. However, a number of valuable lessons, especially in the epidemic control of ringworm of the scalp, have been emphasized by the work of the Public Health Service, especially in the Hagerstown epidemic. From such studies and those of other workers it was agreed that it is important to lay down some regulations for the sterilization of barbers' instruments, the following having been recommended by the Public Health Service:

1. A container which can be heated either by gas or electricity, containing mineral oil of medium viscosity such as liquid petrolatum, having a boiling point from 150 to 250 C., the oil to be kept at a temperature betwen 90 C. and 100 C.

2. The electric clippers to be brushed or wiped free of hair after each child's head is clipped, and the blades and lower part of clipper to be immersed in the hot oil for at least one minute. The power in the clipper can be turned on while it is in the oil for a few seconds in order to agitate the blades and allow the oil to get into the crevices. The use of oil does away with the possibility of any damage to the instruments. When the instrument is lifted out of the oil it can be wiped off with a clean towel and the clipper is ready to be used on the next child.

3. Such a sterilizer can be made by a barber supply house. It can have an automatic thermostat connected with the heating device so that when the thermostat is set at 100 C., just enough heat is being applied to keep the oil at the required temperature.

4. It was found that a 1 per cent soluton of lysol, or liquor cresolis saponatus USP at 100 C. will also sterilize in two minutes.

5. Barbers' hair-cutting cloths should be sterilized by boiling, as should soiled clothing and bedclothes of infected children.

The following plan of treatment and epidemic control was suggested in part by the U. S. Public Health Service with a number of modifications by the author:

1. Infected children should not be kept away from school. Better care and control can be practiced by continuous supervision of infected children in the schools where diagnostic centers should be established.

2. Examination of all children below high school age (puberty) with the Woods light to pick out the infected cases. Care must be taken that children at home, i.e., below school age, in families with infected children also be examined.

3. Establishment of treatment centers in each school where there are sufficient pupils. Each center should be equipped with a Woods light and should have properly trained teams to administer and demonstrate local therapeutic measures.

4. Where adequate facilities and properly trained technicians are available, the most reliable thera-

peutic procedure for the treatment of tinea capitis is still roentgen epilation. However, failures and recurrences will take place unless proper postepilation treatment is carried out. It must be emphasized that when large numbers of cases are to be treated, it is not practical to resort to roentgen therapy as the first method of attack to stop the spread of the epidemic.

5. Trained personnel should be employed to give the treatments when possible. If treatment is to be given at home, the examination with the Woods light is done while the parent or the person who is to carry out the treatment is present. In this way areas of fluorescence are pointed out and marked with a skin pencil. They are instructed to treat these areas especially.

6. Each infected child must have the hair clipped close to the scalp and kept short by clipping the hair every ten days. Loose hairs may act as foci of infection. The parents should be instructed to examine the headgear of the children, especially the boys, as old infected hairs may be present to act as foci of reinfection.

7. The parents are warned of the role of the barber shop as a possible focus of infection. They should insist that the barber carry out the suggestion of the United States Public Health Service for the care of barbers' equipment.

8. Shampooing of the head should be done before each visit to treatment center or physician.

9. The children under treatment should wear close-fitting skullcaps at all times to prevent infected hairs from falling on other children, the caps to be worn in the classroom. Each child should have at least four or five caps. The cap should be changed daily and boiled for ten minutes before washing. Only the mother should remove the skullcap.

10. No matter what the local therapy decided upon, it must show the following: (a) be non irritating, (b) tend to stop the progress of the infection, (c) tend to loosen infected hairs, and (d) show a dimming of fluorescence of the infected hairs.

11. Manual epilation under the Woods light at least once a week is of prime importance in obtaining a cure in a large percentage of the cases treated with local medications.

12. If after thirty treatments to the scalp of a proven local medicament there should be noted a spread to other areas of the scalp, a change shou be made to another medicament which has prov of therapeutic value in at least 30 per cent of a fai large number of cases treated. If after another thi days' trial there is no progressive improveme roentgen epilation should be resorted to. If a chan in local therapy is resorted to, we must bear in mi that fungus-infected hairs may fluoresce for tv weeks after the fungi are dead.

13. Parents must be given written and verl instructions at the first visit and reinstructed seve times during the course of treatment and observ tion.

14. A case is considered cured only when four six weekly examinations reveal the absence fluorescence. The last visit should include, as a fir check, cultures and direct examination of any su pected hairs.

In a recent paper Schwartz[9] had made a numb of additional suggestions for control of the epidem which are well worthwhile enumerating. They a as follows:

1. Meeting with City Council, Mayor, Board Trade and local newspaper representatives to pr vide money and publicity for the control of th epidemic.

2. Meeting with Superintendent of Schools to ob tain cooperation by establishing treatment cente in the schools and permitting infected children t wear caps in the classrooms.

3. Meeting with the Parent-Teacher Associatio to obtain their cooperation: (a) to permit the clip ping of hair of infected children in school every 1 days; (b) to provide caps for infected children an to sterilize them daily; (c) to shampoo the hair o infected children every morning before coming t school; (d) to provide individual combs, brushe towels and beds for infected children; (e) to in struct their children not to change caps, not to re heads on the back of movie seats; (f) to shampo the heads of non infected children immediately o return from the barber shop; (g) for teachers to se that infected children wear caps in the classroom.

4. Meeting with the local Medical Society to co operate by sending all infected children to the treat ment center.

5. Meeting with the Barbers' Association to co operate by refusing to cut the hair of infecte children and sending them to the treatment centers

to sterilize all implements after using them to cut the hair of non infected children.

6. Meeting with the owners of motion picture theaters to obtain the cooperation by examining the plush and mohair backs of seats for fluorescent hairs with the Woods light after the last performance every night, and burning any that are found.

REFERENCES

1. Schwartz, Louis, Peck, Samuel M., Botvinick, Isadore, Lobowitz, Armand, and Frasier, E. S.: Control of Ringworm of Scalp, J.A.M.A., 132:58, Sept. 14, 1946.

2. Public Health Bulletin No. 294.

3. Peck, Samuel M.: Suggested Methods for the Control of the Present Epidemic of Tinea of the Scalp., Penn. Med. J., March. 1947, Vol. 50, 569-573.

4. Rothman. Stephen, Smiljanic, A. M., and Shapiro, A. L. Proc. Soc. Exper. Biol. & Med., 60:394, 1945.

5. Rothman, Stephen, Smiljanic, A. M., Shapiro, A L., and Westkamp, A W.: The Spontaneous Cure of Tinea Capitis in Puberty, J. Invest. Dermat., 1946.

5. Lane, C. Guy: Personal Communication.

6. Carrick, Lee: Methods of Local Therapy for Tinea Capitis Due to Microsporon Audouini, J.A.M.A. 131:1189-94, August 10, 1946.

7. Keeney, Edmund L.: The Fungistatic and Fungicidal Effect of Sodium Propionate on Common Pathogens, Bull. Johns Hopkins Hosp., 73-379, November 1943.

8. Miller, J. L., Lowenfish, Philip, and Beattie, G. F.: Treatment of Tinea Capitis, J.A.M.A., 132:67, Sept. 14, 1946.

9. Schwartz, Louis: Public Health Aspects of the Treatment of Tinea Capitis, N. Y. State J. of Med., 1782-85, August 15, 1947.

10. MacKee, George M., Herrmann, Franz, and Karp, F. L.: A New Treatment for Anthropophilic Tinea Tonsurans (Microsporon audouini), J. Invest. Dermat., 7:43, February, 1946.

11. Strickler, Albert: Tinea Capitis, J.A.M.A., 132:65, Sept. 14, 1946.

PAINLESS LABOR WITH HEAVY NUPERCAINE

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THE relief of the pains of labor has been a challenge to both obstetricians and anesthetists. The employment of a spinal injection, whether extradural (caudal type) or intradural (saddle block), is the test of anesthetic techniques applied to this problem.

Obstetricians and anesthetists agree that no matter which method is used it should be absolutely safe for both baby and mother. It should be easy to administer, and until enough anesthetists are available the obstetrician should be able to do it himself. Furthermore, it should not require the constant attendance of the obstetrician or anesthesiologist.

It is our opinion that an intradural block, in contrast to an extradural block, more closely fulfills these requirements. Being a single dose spinal injection it is simple in administration and requires no special technical training. If one learns the contraindications, the immediate complications and treatment of an intrathecal anesthetic agent, the potential danger to the mother is obviated. There is absolutely no danger to the fetus. And finally, the administrator of the injection need not remain constantly in attendance after the first twenty minutes.

The method of Parmley and Adriani[1] is relatively safe. The dosage of anesthetic drug is very small, and the danger of a severe drop in blood pressure is quite remote. There is also less danger of a vascular injection than with the caudal type of anesthesia and the danger of infection is very minimal since there is no indwelling needle or catheter in close proximity to the anus.

Though it is recognized that Nupercaine is more toxic than other drugs used for intrathecal injection, it is our opinion that the small dose required actually discounts this degree of toxicity. The injection may be safely repeated after 20 minutes if a failure occurs.

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MECHANISM

The sensory nerve fibers to the uterus, cervix, and lower uterine segment are derived from the 12th thoracic, the lumbar, and sacral segments. The motor control is believed to arise higher in the cord.

The sensory and autonomic fibers of a mixed nerve are more sensitive to the drug than the motor fibers. With the use of a hyperbaric solution, the motor nerves will be affected in the region where concentration of the solution takes place, which is in the sacral segment. Thus both the sensory and motor nerves to the perineal area are anesthetized, producing a well relaxed perineum.

PROCEDURE

The solution and technique as described by Parmley and Adriani[2] was used and followed. The solution is prepared by thoroughly mixing 0.5 of a cc. of a 1 to 200 solution of Nupercaine in 0.5 cc. of 10 per cent glucose.

The patient sits upright at the edge of the bed or table supported in front by a nurse. Her back is prepared for a spinal injection, and the skin and interspinous tissues are infiltrated with 1 per cent procaine over the 2nd, 3rd, or 4th lumbar interspaces. The lumbar puncture is performed and the solution injected when no uterine contraction is occurring. This timing of the injection is very important. The needle is withdrawn, and the patient remains in the upright position for 20 to 40 seconds. She is then placed in the recumbent position with a pillow under her head.

We have used this technique for analgesia and anesthesia, or as a delivery anesthetic. For analgesia and anesthesia the block was not given until labor was fairly well along. Dilatation of the cervix was at least 6 cm. and uterine contractions were occurring every 3 to 4 minutes. As a delivery anesthetic we had the patient remain upright for 45 seconds thus producing anesthesia of the perineum rapidly and effectively.

RESULTS

The 200 cases we are reporting were run in two series. In the first 100 cases we followed the technique of Parmley and Adriani, giving the injection mostly in the 4th lumbar interspace, and rarely in the third. In the second series, we gave the injection in the 2nd lumbar interspace, feeling that the percentage of pain relief would be increased. A comparative table between Parmley and Adriani's and our own results is as follows:

	PARMLEY AND ADRIANA 100 CASES	BERLOWE AND HERRI 1ST 100 CASES	2ND 100 CAS
Complete Relief of Pain	79%	76%	96%
Partial Relief	7%	14%	3%
No Relief	Repeated Block	5%	1%
Analgesia, but No Perineal Anesthesia		1%	
Perineal Anesthesia, but No Analgesia		4%	
		17%	8%
Postspinal Headaches	0	(9% Severe 8% Mild	(3% (5%
Postpartum Hemorrhage	0	0	0
Nausea	15%	1%	4%
Vomiting	12%	2%	2%
Urinary Retention	0	0	0
Hypotension with Bradycardia	3%	0	0

ANESTHETIC COMMENT

Our primary interest with spinal block was in th relief of pain. Our results and those of other in vestigators are for the most part consistent. Th dramatic change that occurs in the labor room an the deep gratitude evidenced by the laboring woma is something that must be experienced to appreciat

Complete relief from labor pains can be promise to the suffering woman with one injection. This i particularly so when the injection is given in th 2nd interspace as is shown by the improved result in our series of cases. However, no failures nee occur for it is safe to repeat the injection.

Relief from painful uterine constractions become manifest from 1 to 4 minutes. This lasts for 1 to hours. Perineal anesthesia appears within 5 to 1 minutes. This lasts from 2 to 4 hours.

The upward spread of the anesthetic with a 2n lumbar injection has been to midway between th symphysis and umbilicus. With the technique a described, and a slow injection of the solution— to 10 seconds—the level has never been higher.

The great majority of the patients cannot fle their lower extremities. This varies from a slight t a severe motor weakness. They all could move thei toes.

There is no relationship between dosage and th length of time that relief from pain lasts. We hav varied our dosage from 2.5 mg. to 5 mg. With larger dosage however the perineal anesthesia i more profound and lasts longer. We find that 2. mg. is adequate.

Timing of the block is most important if only e injection is contemplated. There is no contra-dication however to a repeat block.

The average drop in blood pressure was 10 millieters of mercury. The greatest was 20 millimeters. he latter drop occurred with the higher dosage. Ve have had no severe hypotension or bradycardia i this small series.

OBSTETRICAL COMMENT

The perineal relaxation that occurs with a spinal lock greatly facilitates delivery. Forceps traction, anual rotation of a transverse or posterior occiput d breech extractions are easier and less traumatic an with inhalation anesthetics. Episiotomies are ot as extensive.

Spontaneous rotation of occiput posterior positions take longer under spinal block. This is due to wo factors. The lack of perineal and soft part sistance and the absence of the bearing down forts of the patient during the second stage. The cidence of posterior occiput engagements is greater. We shall report this in a later paper.

Spontaneous delivery can occur with the patient operating and bearing down at each contraction. Ve however discontinued all voluntary efforts early the series because too many of these patients eveloped postspinal headaches.

With breech extraction, manual rotation and ccasionally with forceps traction the patient will complain of moderate discomfort. A few ether whiffs during the maneuver relieves this.

No difficulty in resuscitating the newborn was encountered.

The block is particularly good for premature deliveries. No preliminary medication need be given, other than oxygen.

COMPLICATIONS

We encountered no immediate complications other than nausea and vomiting. This was transitory in nature. We are not certain that this was due to the anesthetic. We had no severe hypotension.

The only troublesome complication was headache. This was usually delayed, appearing on the second or third day. The complaints were either localized to the frontal or occipital areas, or to the neck. The latter complaint was more of a stiffness and was most bitterly complained of. These patients did not have a postspinal hypotension.

SUMMARY

A series of 200 cases is reported in which Heavy Nupercaine was used for the relief of pain in labor. We feel that these results are good and merit further investigation with this type of anesthesia.

BIBLIOGRAPHY

1. & 2. Parmley and Adriani, The American Journal of Surgery, LXXI, No. 1, January, 1946—pp. 12-18.

PUERPERAL SUBPERITONEAL HEMATOMA — CASE REPORT

FREDERICK W. SHULL, M.D., and HERBERT THOMS, M.D., *New Haven*

PUERPERAL hematoma has been defined as "the effusion of a greater or lesser quantity of blood into the connective tissue spaces of some portion of the genital tract or into the structures immediately adjacent to it, in contradistinction to hematocele formation in which the blood is poured out into the peritoneal cavity and then becomes encapsulated."[1]

The vulval and perineal varieties of hematoma are not greatly uncommon and usually not serious. Less frequent is vaginal hematoma in which the blood collects in the connective tissue of the vaginal wall. This variety also usually is not of serious prognostic importance although if it occurs during delivery it may cause obstruction in the birth canal.

Still less frequent is the subperitoneal type of hematoma in which the blood lies beneath the peritoneum but above the pelvic floor. According to Williams it usually follows incomplete rupture of the uterus or deep cervical tears and in a small number of cases, as in the case here reported, the hemorrhage apparently results from rupture of the vessels within the broad ligament.

It is important to consider further Williams' excellent monograph on this subject because it has

a bearing on the surgical treatment of the condition if this is decided upon. This author quotes Perret's injection experiments made at autopsy which showed that the hemorrhage was capillary in character, an observation also borne out in Williams' case, surgically treated, in which the hemorrhage was seen to be a capillary ooze from the anterior and inferior surface of the bladder.

The decision as to treatment other than conservative may call for very careful observation, for if the hemorrhage is allowed to extend too widely surgical treatment may carry great risk. On the other hand, experience has shown that most cases can be treated conservatively as was done in the present instance.

The patient, a 39 year old married para VIII gravida XII abortus III, was admitted to the obstetrical service of Grace-New Haven Community Hospital on October 31, 1947 in active labor and with a history of ruptured membranes. The present pregnancy had been essentially uneventful. No toxic symptoms had been noted and blood pressure averaged 104/70 throughout. Weight gain during the pregnancy was 40 pounds. She had noted increased vulvar varicosities and some venous varicosities of the right leg during the third trimester. Two weeks previous to admission the patient had noted a heaviness in the pelvis. She experienced no urinary symptoms other than frequency. The patient was Mazzini Negative, Group A, Rh negative. Expected date of confinement was October 17, 1947.

The patient's past history is mainly obstetrical, there having been eight full term baby girls and three early abortions between the years 1933 to 1947. The patient had an appendectomy performed in 1933 at which time she was four months pregnant. Her labors varied in time from 55 minutes to 2½ hours and were productive of babies weighing between 7½ and 8 pounds, all being born spontaneously and without intra partal or post partal incident. Of her abortions two were induced, the other being spontaneous, and all of them required curettage for completion.

In the present admission after a rapidly progressing three hour labor the patient was delivered spontaneously of a 3815 gram baby boy, a few whiffs of nitrous oxide being utilized for anesthesia during contractions. The third stage of labor was completed in thirty minutes, the placenta being expressed from the vagina. Blood loss was estimated at 50 cc, blood pressure at the end of labor was 105/75. The placenta on inspection appeared to be intact. The patient was given 1 cc of pitocin and 1 cc of ergotrate after the delivery of the placenta.

An hour after delivery the patient was returned to the obstetrical floor at which time she noted the gradual onset of right lower quadrant pain which rapidly became quite unbearable. Three hours after delivery the fundus was found to be 6 cm. above the umbilicus and resting beneath the costal margin on the left. The uterus was firm; lochia was moderately heavy with several clots of blood being expressed. Along the lower right margin of the uterus an extremely tender indefinite mass extending to about 4 cm. below the umbilicus was made out. There was no rebo tenderness nor spasm. Blood pressure at this time was 11 with pulse 87, somewhat weak. The diagnosis of hemorrh into the right broad ligament was made at this time.

During the next 12 hours the right lower quadrant p persisted, relieved only by morphine. Vital signs remai stable. However, blood studies showed a drop from 14 gr hemoglobin on admission to 11.5 grams. An x-ray of lower abdomen at this time showed the presence of a la mass, extending from the pelvis to the level of the sec lumbar vertebra on the left interpreted as being the ute and a suggestion of another mass on the right of the ab men extending down into the pelvis which mass thought to represent the hemorrhage into the broad li ment. Inasmuch as the patient's blood pressure stabili at about 100/70 with pulse of 88, it was decided that patient should be watched carefully and laparotomy carr out if there were signs of further hemorrhage. Con quently, the patient was placed on blood pressure and pu every 15 minutes and penicillin in addition to the rout recordings post partum medications. Morphine sulfate o gram was required to keep the patient comfortable duri the night, her blood pressure remaining in the vicinity 100/70 with pulse at 80.

During the afternoon of the first post partum day t patient noted the extension of pain to the right flank. this time the mass in the right lower quadrant was w defined by palpation extending to the lower margin of t umbilicus. It remained very tender, though less so th on the day of delivery. There was also marked tenderne in the right costo-vertebral angle, though no fullness n mass could be demonstrated here. The uterine fundus r mained high on the left and was firmly contracted. T lochia was moderate with only occasional small clots bei passed. The distribution of pain and a drop in red cou to 3.1 million with 10 grams of hemoglobin suggested t continuance of hemorrhage retroperitoneally along t ureter into the right sub-renal area. During the first po partum day she was kept fairly comfortable with codei and aspirin, morphine being required only twice when t other medications seemed ineffective. Toward the end the first post partum day the blood pressure had falle to 80/55 with pulse between 80 and 90 and red count 2.47 million with 8 grams of hemoglobin.

The second post partum day she felt more comfortab with only moderate right lower quadrant and flank pai which was fairly well controlled with codeine and aspiri She was given 500 cc of whole blood which was repeate the following day. The patient felt lethargic and dizzy a well as anorexic. Intake and output of fluid were adequat Toward the end of the day she passed a 4x6 cm. sized clo of blood. However, the uterus remained firm, the righ lower quadrant mass being quite distinctly made out 4- cms. above Poupart's ligament and being still quite tende to palpation.

By the fourth post partum day the patient seemed a littl brighter and more comfortable, being conscious only o dull aching pain in the lower abdomen and flank region Her temperature rose to 101° at 4 P. M., this being the firs time the temperature had been elevated. Blood pressur remained at 100/65 with pulse 90. Blood count stabilize

.09 million with 11 grams of hemoglobin. At this time mination revealed slight tenderness in the legs. A cathe- zed urine specimen revealed occasional short rods in the ment.

On the fifth post partum day the patient was seized sud- ly with a violent shaking chill with rapid temperature to 105.6°. She became dyspneic and apprehensive. Phys- examination at this time revealed that the chest was r. The uterus was firmly contracted and in the left er quadrant. There was marked right costo-vertebral derness on the right and slight calf tenderness on the t. Homan's sign was negative. Blood culture taken dur- the shaking chill subsequently showed no growth. The ent was given sulfadiazine in full doses to supplement penicillin. The next day (post partum day #6) her perature was 102°. The blood pressure remained 96/60, se 88. Lochia continued to require the use of 4-5 pads ing the day.

During the sixth post partum day the patient noted the dual onset of chest pain which was most prominent in right lower chest, though she had some fleeting pain the left side also. The pain here was definitely increased deep inspiration. Examination of the chest revealed little ept for dullness to percussion and diminution of breath nds in the right base. X-ray of the chest revealed no normalities other than an elevated diaphragm on the ht. Also, the roentgenologist remarked that "the whole ht sub-diaphragmatic area is of greater density than nor- lly observed." At this time temperature was 101°. Red nt was 2.16 million with 9.15 grams of hemoglobin. She s given another 500 cc transfusion of compatible whole od.

On the eighth post partum day temperature was 99°; the ient continued to complain of pain in the lower right est without cough or sputum. There appeared slight but finitely demonstrable ankle edema on the right along with nimal calf tenderness which suggested the possibility of pelvic thrombophlebitis with pulmonary embolism. How- er, during the next three days all symptoms became less ere; the temperature gradually flattened out, the edema appeared and general improvement was apparent. Intra- nous pyelograms revealed a normal urinary tract with demonstrable deviation of the right ureter. Pelvic ex- ination at this time revealed the uterus to be involut- g well. There still remained moderate tenderness in the ht costo-vertebral angle and the right lower quadrant ass which was quite firm now extended from the broad ament to about 3 cm. above the inguinal ligament and as considerably less tender than previously.

The patient's temperature flattened out after the 13th post rtum day. Her lochia remained moderate rubra until the th day and with continued improvement she was gradu- ly mobilized and was discharged home on the 21st post rtum day on a regime of semi-bed rest. At the time of discharge the red count was 3.86 million, hemoglobin 12 grams. Other than for weakness and some discomfort in the right lower quadrant she felt fairly well. Discharge pelvic examination revealed the cervix to be fairly well healed with only a minimal amount of erosion on the anterior lip. The uterus was anterior, firm, symmetrical, freely movable and well involuted, reaching to one finger breadth over the symphysis. The left adnexal region was negative. On the right there was a sense of resistence, the right fornix being more shallow than the left. Abdominal examination revealed the persistence of a firm, slightly tender, fixed mass rising three finger breadths above the inguinal ligament.

The patient was seen in clinic two weeks after discharge at which time she had no complaints. On examination of the pelvis there was no trace of the mass and the uterus was fairly well involuted. She was seen again three months post partum at which time she claimed to be in excellent general health. At this time she complained of occasional "twinge" of pain in the right lower quadrant and kidney region on the right. She had not had a menstrual period since delivery which led her to inquire as to whether she were not again pregnant. Pelvic examination at this time was essentially negative, although there was a very slight sensitiveness in the right parametrial region. X-ray of the lower abdomen at this time was read as indeterminate.

SUMMARY

Grandimultiparous female who, following the spontaneous delivery of a term-sized baby after a three hour labor, sustained a hemorrhage into the right broad ligament which apparently extended retroperitoneally up along the ureter to the region beneath the diaphragm. The complication was treated conservatively, with a favorable outcome after a prolonged convalescence.

A case of subperitoneal hematoma of considerable proportion occurring in a multipara following a short spontaneous labor has been described. Emphasis is placed on the importance of careful and continuous observation during the bleeding phase of the condition in order that surgical intervention may be instituted promptly if necessary. Also, it should be remembered that the great majority of cases may be successfully treated by conservative management.

BIBLIOGRAPHY

1. Williams, J. W.: Subperitoneal Hematoma following Labor not associated with lesions of the Uterus. Trans. Am. Gynec. Soc. 1904.

MEDICINE AND THE FUTURE

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SOMEWHERE in sacred literature there is a brief word-picture of the restless and uneasy citizen, unable to sleep, pacing the dark streets of the walled city and calling to the watchman on the walls: "Watchman, what of the night?", and the reassuring answer,—"The morning cometh." And we, looking into the dim future, and calling anxiously to our watchman seem to hear the same comforting answer. But perhaps the watchman, gazing toward the eastern sky, dazzled by the first flush of the rising sun of knowledge, ushering in the dawn of the scientific era in medicine, fails to hear the ominous rumblings on the left, or to note the dark shadows drawing near. If I were a preacher, I should take for my text "A voice crying in the wilderness," and I should remind you how very few listened to that voice. If I were an orator I should quote the fiery periods of William Pitt as he warned the British Parliament that a continuation of its policies would result in the loss of the American Colonies, and I should not need to remind you that they would not listen. Since I am neither orator nor preacher, but only a physician who is becoming alarmed over what he believes to be a menace overhanging our profession, I must content myself with the statement of my thesis and the presentation of factual data to support it. Simply put, it is this: During the past twenty years there have been rapid and extensive changes in the traditional function of the hospital in its relation to the practice of medicine, and the profession of medicine is now entering a critical period in which it will be decided whether the fields of diagnostic, therapeutic and preventative medicine shall be dominated by physicians or hospitals. Much more recently the medical school has entered the practice of medicine, in competition with its graduates, adding new confusion to the already complex problem of how medical care sh be given and by whom.

As every treatise on semantics points out, mu useless and unprofitable disputation occurs becau those who dispute are attributing different mea ings to the same words. Let me make it clear the that the word "hospital" does not signify, in th discussion, the familiar and friendly place whe the physician carries on part of his practice; a institution that probably would not harm him if could, and, in all likelihood could not harm hi much if it would. On the contrary, the word "ho pital," as I am using it, means that impersonal ar abstract thing, the hospital world, the association hospitals, the microcosm of the planning commi sions.

Whether deliberately or not, current tendenci on the part of hospitals find their keynote in th first recommendation made by the Committee o the Costs of Medical Care. In 1929 the Committe recommended that medical care be furnished b groups, organized around a hospital. Thus the ho pital becomes the dominant factor in the deliver of medical services. The importance of the trad tional family doctor as the prime figure in a pr gram of adequate medical care is obscured in a tren toward institutionalized medicine with the hospit as the central figure. Is this an exaggeration? L me quote to you an excerpt from an address recentl delivered by an executive of the American Canc Society: "The care of the cancer patient naturall revolves around the hospital. There he had his fir treatment; there he will return for subsequent care. There was no ulterior motive underlying this an the speaker had no intention of uttering any radic or controversial statement. He was simply statin as a matter of fact, something that seemed to him t be indisputable and quite natural.

Steps toward the goal of institutionalized med cine were taken when hospitals began the operatio of pay clinics and outpatient departments in con

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ition with the private physician's office, abandng the old concept that outpatient services and t-pay clinics should be maintained only in teach- institutions where patients could be used for nical material. Further steps were taken when the iddle rate" plan was adopted by a number of pitals, in which patients were admitted on an usted fee basis including not only the hospital , but the bill for medical care as well. Other hosals instituted "flat rate" or "all inclusive" plans der which a patient could be admitted to the hosal for diagnostic services and pay a flat fee cover- the complete cost for medical services and spital facilities. Still further and more radical steps re taken when hospitals began the sales of insurce plans which offered as benefits not only the of the physical facilities of the hospital, but the vices of medical specialists as well.

We are living in an era of great social change; an comparable, perhaps, to the end of the feudal riod and the inception of the modern industrial ilization. Powerful forces are urging upon us the cialization of society, and it must be obvious to ery reasonably literate person that the socializan of medicine is one of the first steps towards the hievement of that objective. What is not so vious is that the expanding activities of Blue oss plans, some of our large teaching hospitals and edical schools may well form the spear-head of the tack which has for its goal the substitution of cialization for free private enterprise. The very sence of socialism is the subjugation of the invidual, while a fundamental tenet of our system democracy is the importance of the individual. is not by accident that we say "the man in the reet" rather than "the men in the street." Every dividual is hedged around with rights, protecting is peculiar person and his peculiar property. Since ciety is only a very large group, the social planner as seen that although it is difficult to persuade men hand over their personal rights and freedoms to ne State, it will be less difficult to get them to rrender these to smaller groups over which they ppear to have some control. This done, and the maller group having assumed the privileges once elonging to the individual, the final step of transerring them to the larger group called Society or he State becomes much easier.

I do not mean to attack or belittle the Blue Cross lans. On the contrary I regard them with admiration, and I believe that they serve a very useful purpose, especially where they operate in conjunction with voluntary medical care plans. The trouble with them is that they appear to be unwilling simply to provide hospital care; they insist on turning group hospitalization into group medical care, with the medical care being furnished by the hospitals. Here begins the first step in the subjugation of the individual and his disappearance into the comparatively small group.

Of course it will not do simply to make this flat statement and pass on. Perhaps the statement is a purely emotional one, not based on observable facts. Actually, it isn't very difficult to offer some documentation. Clinical pathology, anesthesiology and radiology are now claimed as hospital services. The argument for this claim reminds me somewhat of that attributed to the Rev. Mr. Still when his brother announced the discovery of osteopathy—"John, you may be right and praise God, there's money in it!" But if hospitals may include these medical services, what will prevent them from including cystoscopy, tonsillectomy and normal confinements? The hospital administrator replies that the hospital hasn't the least desire to practice medicine, but at the same time he issues such documents as:

"It's a Fact"

By Melvin L. Sutley, Supt., Del. Co. Hospital, Drexel Hill, Pennsylvania

"Both ante-natal and post-natal clinics are operated by the modern hospital.

"Everything known to science, including x-ray machines and other costly equipment, is called into play for the benefit of both mother and child. Thus an expectant mother, who places herself early under the protection of a hospital's maternity department can avail herself of medical observation and care for more than a year.

"In the ante-natal clinic, the prospective mother's general health is improved. Her strength is 'built up.' If obscure symptoms exist, they can be treated and corrected, before the infant is born . . .

"The post-natal clinic is operated for the benefit of both mother and child. They may make visits every month for an entire year, receiving advice as to the correct diets based on the baby's weight and health, and correction of any troubles which may develop.

"During this period there may be occasions when x-ray may be required again, for either mother or

infant. And the treatment may involve the use of much other equipment, available now in the hospital, undreamed of even twenty-five years ago . . .

"If he's a clinic baby, the chances are that both he and his mother are healthy and happy, with all the health advantages that science can bestow."

You notice, I suppose, the credit given and the reference made to the physicians who see these cases?

The official publication of the American Hospital Association has stated flatly: (*Hospitals*, May 1937, p. 73) "Diagnosis, treatment, and the care of the ambulatory sick become increasingly the functions of the hospital as the hospital develops into the center of community health activities." Again, (*Hospitals*, September 1937, p. 67) we read, "The patient, whatever his economic status is entitled to receive the necessary service of the clinician, the surgeon, the pathologist, the radiologist, the nurse and the lay people who attend him. *All these services are a part of the hospital* . . . On p. 63 of the same number, the diagnostic skill of the modern hospital is praised in these words "the hospital is an indispensable public utility because of the wide variety of diagnosis and treatment it offers." Says the Board of Trustees of the A.H.A., "Provision of medical services in hospitals is part of the responsibility of hospitals," and W. P. Slover, in the official Journal of the A. H. A. advises hospitals to increase their revenue by educating the public to more regular use of the laboratory, the x-ray and diagnostic services for systematic check-ups on their health.

There is grave doubt that such hospital activities are lawful, and it is quite likely that hospitals and medical schools that offer medical services to the public are violating the laws which forbid corporations to practice the learned professions. The Journal of the A. H. A. has stated editorially that "the laws regulating the practice of medicine by corporations do not apply and were never intended to apply to hospitals." Michael Davis in a paper entitled "Do Corporations Practice Medicine" says, "the hospital corporation, if it is a corporation, is not practicing medicine in a legal sense." The various Supreme Courts, however, seem to be in something less than complete agreement with these theses, and have regularly ruled that corporations cannot evade the laws against the corporate practice of medicine by hiring licensed physicians. A typical decision is that by the Supreme Court of Massachusetts in an action entitled McMurdo v. Getter (10 NE 2nd 139), in which the Court said: "the rule is generall recognized that a licensed practitioner of a profe sion may not lawfully practice his profession amor the public as the servant of an unlicensed person corporation; and that, if he does so, the unlicense person or corporation employing him is guilty practicing that profession without a license . . In the absence of statutory modifications in fav of hospitals or others, the same rule . . . applies

The growing tendency of medical schools to e gage in the practice of medicine is a disturbin phenomenon. It is quite true that their tuition fe and their endowments no longer suffice to defra the expense of educating the medical studen Nevertheless, their legal and moral right to enter th practice of medicine seems extremely doubtful. must be clear that if the Supreme Court decisio just quoted is to be regarded as law, (and suc decisions *are* law unless they are modified by legi lation) the medical school has no more right t practice medicine than does a hospital. The moralit of a medical school competing with its own gradu ates is a little shaky, but of much greater significanc is the effect of such competition on the future medical practice and the public health. In the pas thousands of young men have been led to enter th study of medicine by reason of the affection an admiration which they felt for the physician wh cared for their families, and by observation of th obvious fact that the doctor lived a cut better tha the laborer, the salesman, and the clerk in a stor But think for a moment: who can blame the pros pective patient who reasons that he would be foolis to see Dr. Brown when he can as well go to th medical school and have the services of the grea men who are the professors. The patient, of course is quite unaware that very rarely, indeed, will he se the professor, and that there is no particular reaso to believe that a given doctor will administer an better medical care in a medical school clinic tha he would give in his office. As the family physicia thus loses prestige and income, the young men wh formerly emulated him will be less and less incline to do so, the practice of medicine will become les and less attractive, and fewer and fewer young me will enter it. As the amount of tuition receive declines the problem of the medical school will be come more acute, and its operation by a paterna government will at last be the only possible solutio to the problem. "Whom the gods would destroy they first make mad," said the ancients.

ut, you will say, the American Medical Associa-
n will surely say something about such things as
se. It has spoken, and very definitely. In the code
ethics we read: "It is unprofessional for a physi-
n to dispose of his professional attainments or
vices to any lay body, organization, group or
ividual, by whatever name called, or however
anized under terms or conditions which permit
irect profit from the fees, salary or compensation
eived to accrue to the lay body or individual
ploying him." In 1936 the Judicial Council of the
merican Medical Association said . . . "It
uld seem that in this time of extensive changes in
spital economics the point had arrived at which
ther marriages between hospitals and staff physi-
ns that made the doctor of medicine the servant
the hospital should be stopped and a series of
empts at divorce among marriages that have
eady taken place should be instituted. Our ac-
pted ethical principles are adequate at the present
e and hospitals would be of invaluable assistance.
s not an impossible task but will need a militant
al and national ethical spirit behind it and a
wning on those individuals in the profession who
personal grounds do not object to the gradual
bjugation of the medical profession in the growth
hospital domination."

In 1937 the House of Delegates of the American
edical Association defined hospital care as consist-
g of room, board, ordinary nursing care and
utine drugs. Do the hospitals bow to this supreme
thority in American medicine? Not at all; they
nply inquire editorially in their official journal:
s it the prerogative of the medical profession to
cide on hospital policies—? Should the trustees
of hospitals included in reputable non profit group hospitalization plans be told what they must and must not do?" If I have not made out a case in support of my thesis, the fault is my lack of skill. I feel very sincerely that the menace of hospital domination is a real one, likely to remove the hands of its natural trustee, the physician, the priceless heritage of medicine. I think that you will agree the answer to rhetorical questions of the hospital journal should be: "Yes, it *is* the prerogative of the medical profession to decide on hospital policies when those policies concern the field of medical care." "Yes, the trustees of hospitals included in reputable non profit group hospitalization insurance plans *should* be told what they must and must not do when the subject under discussion is the dispensing of medical services." The medical profession has neither the right nor the wish to dictate hospital policies to hospitals but cannot and must not permit the forcible translation of the practice of medicine into hospital service. Nor is the invasion of the field of the practice of medicine by the medical school any more tolerable, and its justification is equally difficult.

I ask you to acquit me of ulterior or selfish motive. I will neither gain nor lose more than any of you if these things do or do not come to pass, although any person who takes a decided attitude in a controversial matter is certain to lose something in that he surely will incur new enmity and increase the disesteem in which he may already be held in some circles. But I have a simple, perhaps even childish idea that truth and the right are worth striving for, and I cling to the simple belief of old,—"If God be with us, who may be against us."

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EDITORIALS

Medicine in a Planned Economy

In a recent issue of the *British Medical Journal* (March 13, 1948), under the title of "Where are we going?" Dr. Ffrangcon Roberts of Cambridge, England, has some interesting comments on Medicine in a Planned Economy. He points out the extraordinary expansion which has taken place in medicine, particularly during the last twenty years, expansion involving not only physical facilities but an expansion witnessed by the great army of physicians, nurses and such auxiliaries as radiological technicians, dietitians, laboratory technicians, physiotherapists, social workers, clinical photographers, record librarians, occupational therapists, and hospital physicists, to mention some. The existence of this course of affairs is well recognized. What is not recognized is its acceleration and, as the author points out, nothing short of a decline in population can operate as a limiting factor.

In theory it might be expected that a diminution in disease might be expected when the whole population is adequately fed, housed, clothed and educated. However, there does not seem to be much causal relationship between social conditions and most of the major diseases which fill hospitals. In addition, many unnecessary examinations, particularly in the field of radiology, are carried out through fear of litigation, examinations made not because of their clinical necessity but from fear of severe penalties. The most reasonable hope for the diminution of disease would seem to lie in th advancement of science. However, even here it up against the inevitable, for the concern is chiefl the postponement of a natural termination, "W live in an age of increasingly medicated survival Since we can see no sign of any arrest in th accelerating expansion, and since such expansion incompatible with a contracting economy, it mu be concluded that the limit will be determined b the available resources of manpower or cost, c both, for medicine is not above economic laws an a limited and a planned economy cannot support health service expanding with acceleration which now exhibited.

The author sees these dangers for his country First, money and labor will be spent on trifling ai ments to the detriment of those who are seriousl ill. Secondly, individual attention and matur thought will be replaced by routine performanc and responsibility beyond their capacity will b delegated to subordinates. Thirdly, the threat c freedom of action in dealings with patients will b forced on the medical profession by economi necessity. When this comes if it is at all possible should be self imposed by those who understand th subtleties of clinical medicine and not by those wh only have a bureaucratic acquaintance with it. D Roberts ends his stimulating and thoughtful remark with these words, "We rightly dread any violatio by the State of the sanctity of the doctor-patien relationship, but the preservation of this sanctit

depends upon the full recognition of the doctor and patient alike that individual health and national health cannot be dissociated, and that intelligent but at the same time unselfish regard for his own health is not the least contribution which every citizen must make to national prosperity."

Q Fever

It has been a common experience among medical men that many diseases, originally described as rare or unusual, subsequently become fairly common, either because physicians have learned to recognize them or because, being of an infectious nature, they spread from the location in which they were originally detected. One of the most striking examples of this dissemination of a new infection is brucellosis, which apparently originating on the island of Malta, has now involved a large number of civilized countries, in some of which, the United States for example, it has become a widely recognized disease. On account of the frequency of this sort of a story it seems worth while to call attention to another infectious disease, Q Fever, because evidence is accumulating that it too is spreading far from its original local focus.

The disease, a rickettsial infection, was first adequately described in Australia by Derrick a little over ten years ago. First noted in the employees of a particular slaughterhouse in 1933, it was named Queensland Fever because it originated in that State. Subsequently the alphabetical habit which bureaucracy has fostered in late years, led to an abbreviation to Q Fever, which name has stuck. While it is true that one or two cases of a rickettsial infection which closely simulated Q Fever were described in this Country not long after Burnet had isolated the biologic rickettsia in 1938, the disease did not appear here among any large group of patients until late in World War II, and then at first only in soldiers returning from Southern Europe. There the infection was present and, until its positive identification, went by the name of "Balkan Grippe." However, in the last year or two there have been at least three outbreaks, one in Texas connected with a stockyard, and two in California associated with dairying, which makes it possible that other epidemics are likely to appear when the circumstances are favorable, and makes it desirable that physicians all over the country should be on the alert.

Most rickettsial diseases are conveyed by insect vectors: ticks, mites, lice or fleas, but Q fever differs from the commoner rickettsioses in that it can apparently be conveyed, under certain circumstances, by droplet infection or by dust. This is probably due to two things: (1) the rickettsia is unusually small, almost as small as a large virus, and (2) it is present in enormous numbers in the feces of infected ticks, so that it is probable that it can get into the feces and urine of cattle and be conveyed in the form of dust. That may be the reason why the disease has appeared spontaneously in Texas and California, both of them very dry climates at certain times of the year. For the same reason it is unlikely to appear during the Winter and Spring months in New England, the Middle West, or other parts of the country subject to heavy snowfall or periods of prolonged moisture, except possibly in those closely associated with cattle such as dairymen or slaughterhouse workers. It is true that there have been several laboratory infections, but it is not likely that the disease will appear in others than those associated with cattle except in dry seasons when dust is prevalent. The recent recovery of rickettsia burneti from raw milk by Huebner and his colleagues, however, makes it possible that the disease may occur in dairying districts at any time of year.

Unfortunately there is nothing particularly striking about the clinical features of the ailment. It commonly has a sudden onset with grippe-like symptoms, but may begin gradually. It is a febrile disease with the usual headache, backache and limbache, and with fever which varies widely in duration and intensity in different individuals, is sometimes lacking or may be accompanied by chills or sweats. There is no distinctive eruption, though Derrick described a fine papular rash in about 25 per cent of his patients. There is nothing characteristic about the physical examination except the fact that trivial pulmonary signs in the form of scattered râles are commonly associated with an x-ray picture indicating much wider involvement of the lungs than the physical signs would suggest. In this, however, Q Fever does not differ from many of the so-called atypical pneumonias of recent years.

The urine and blood pictures do not help in diagnosis early in the disease, and if suspicion of its presence is aroused by a patient's occupation, or by residence in a dairying center or near stockyards,

inoculation of blood into suitable animals or agglutination or complement fixation tests with suspensions of the rickettsia Burneti are the conclusive procedures which will lead to the detection of the disease.

G. B.

Progress in Clinical Medicine

The JOURNAL publishes in this issue the first of a series of papers on progress in clinical medicine. In this series we plan to interest our own members in the special and general fields of medicine to prepare papers which will give up-to-date information on various medical subjects written from the standpoint of general interest. A number of subjects for such treatment have been decided upon and we would welcome further suggestions from our readers, both as to subjects and authors. We look forward with great interest to this new department and feel certain that our enthusiasm will be shared by our readers.

Prepayment on the March

Recent reports which give an overall picture of what is going on in this country in medical care insurance sponsored by Blue Cross and Medical Societies show that at the end of 1947 more than 7,500,000 persons were enrolled, that over 90 voluntary plans were in operation in 42 states and that during the year there was a 50 per cent enrollment growth. An even more remarkable growth is seen in the overall voluntary health insurance developments. A survey shows that approximately 30,000,000 persons or one half the working population have insurance against loss of income due to disability, over 40,000,000 have hospitalization, approximately 17,000,000 have surgical benefits and over 6,000,000 medical benefits. These are impressive figures. The great gains which have been made during the past year present an argument in favor of individu responsibility which will be hard to refute by thc who claim that the American public want and a demanding compulsory medical insurance und centralized federal control. The voluntary insuran principal in this country remains a basic need the Free Society which today is being called up to point the way toward better understanding a better living in most of the nations on this eart Man's stature reaches its finest proportions on through his ability to stand on his own feet.

20,000 Years of Service

Over the editorial desk comes a publication b the medical Society of the State of New York bea ing the above title and commemorative of 432 Ne York State physicians who have served their con munities fifty years or more. As a token of appr ciation the Society awarded certificates to the doctors and at the banquet of the Annual Meetin held in Buffalo on May 7, 1947, a Fifty Year Clu was organized. In addition to citations, the boo contains photographs of all but 53 of the grou including 48 photographs of physicians taken at th time they began the practice of medicine. Two c the group have practiced for seventy years. Follow ing the award of certificates at the Annual Meetin a response was made by Dr. Nathan B. Van Ette one of the recipients and a former president of th American Medical Association. The work is a impressive record of service to the public and th example set by the New York Society is a notabl one. In surveying this group of "Fifty Year" doc tors, Connecticut physicians will find many familia names among whom may be mentioned: George I Brodhead, Robert L. Dickinson, John F. Erdman Max Einhorn, Austin Flint, Hermann Grad, Ma Huhner, William A. Jewett, Edward L. Keye Irving W. Potter, Howard C. Taylor, Walte Timme, George Gray Ward, and Francis C. Wood

PROGRESS IN CLINICAL MEDICINE

ANTICOAGULANTS

BURWELL DODD, M.D., *West Hartford*

THE purpose of this article is to present a resumé of the recent experimental and clinical data, and to outline workable and practical methods for the use of the anticoagulants. The history of the development of these substances will be omitted.

Pathological conditions warranting the use of these substances must first be understood. Anticoagulants are used to prevent and treat vascular thrombosis. At the present time the most frequent conditions which are amenable to these drugs is phlebothrombosis and thrombophlebitis. The pathology of the former is formation in a vein or veins of a clot which is loosely adherent to the vein wall, and which extends proximally as a long, friable tail. There is no infection present and little if any perivascular reaction. In thrombophlebitis, however, there is closely adherent clotting all along the involved vein and considerable perivascular inflammatory reaction which may involve the adjacent lymphatic channels.

The most frequent site of these conditions is in the veins of the lower extremities. Clinical evidence points to the deep veins of the calf as the origin of the thrombo-embolic disease which so frequently gives rise to the so-called "silent embolus." The clot propagates upward into the popliteal and superficial femoral veins. The magnitude of such a clot can cause fatal pulmonary embolus when it breaks off.

The predisposing factors of phlebothrombosis or thrombophlebitis may be venostasis due to lack of movement, angulation with obstruction or increased venous pressure in cardiac insufficiency or secondary to obesity. Loewe points out that variable hemoconcentration, increased viscosity of plasma, hyperglobinemia and increased fibrinogen may initiate phlebothrombosis. After operation it is known that platelets increase and become more adhesive. These changes reach a maximum about the tenth post operative day; and may be causative factors.

Another dangerous source of thrombo-embolic disease is in the veins of the pelvis following lower abdominal operations. The incidence of pulmonary embolus after hysterectomy has always been high. It is a well established fact that the older operative patients—especially after abdominal surgery for cancer—are prone to embolus. Here we have debilitated subjects with sluggish circulation who tend to be sedentary.

The next pathological condition for which anticoagulants have been used is coronary thrombosis. Here again the formation and propagation of clot is the important consideration. It is evident that by the time this condition is recognized thrombosis has already occurred. If this process continues it will extend to involve adjacent arterial vessels. Also an infarcted area in the myocardium is produced. In such an area the small vessels—both venous and arterial—will become thrombosed thus precluding the immediate advantage of collateral circulation. In addition, mural thrombi often form on the endocardium in an infarcted area. In turn these may break loose and cause embolic disease. Mural thrombi also develop in rheumatic heart disease, and so may be considered in this category.

In other thrombotic diseases such as cerebral thrombosis, mesenteric thrombosis, and migratory phlebitis the formation of intravascular clot causes ultimate, serious damage. In crushing injuries and trauma where blood vessels are damaged the same holds true. In arterial diseases such as arteriosclerosis and diabetic gangrene preventing of extension of clot is important.

In frost bite, studies were made by Lange and Loewe[6] which demonstrated clumping of red cells in the small vessels of the affected area after release of the initial spasm. After a 72 hour period these cells organize and thrombosis occurs.

In blood vessel surgery the formation of post-operative clot could defeat the purpose of the operation or delay the function of the anastomosis. In cases of embolectomy the same is true.

PROPHYLAXIS AND CLINICAL INDICATIONS

Anticoagulants are used to prevent thrombosis or its propagation. They are therefore indicated in the

pathological conditions just discussed. In sedentary patients over the age of 40 who have undergone a major abdominal operation clinical evidence indicates the prophylactic use of anticoagulants. In cases with a previous history of thrombosis or embolism preventive anticoagulant therapy is also indicated.

In postoperative patients there are clinical signs which should be watched for, and often indicate thrombo-embolic disease. The first is the complaint of tenderness in the legs, especially in the calf muscles. These should be palpated frequently in older patients, and the feet dorsiflexed (Homan's sign) to elicit tenderness. An unexplained postoperative rise in temperature and pulse may indicate beginning, hidden thrombotic disease.

The occurrence of pulmonary embolus is an immediate indication for the use of anticoagulants. Recognition of this condition is usually chest pain followed by coughing up of bright blood, although chest pain alone may be the indicator. X-ray is of aid in differentiating embolus from pneumonia, pneumonitis, pleurisy, or atelectasis. Electrocardiogram is also a useful adjunct.

The prevention of coagulation may be divided into two main categories: the mechanical and the use of anticoagulant drugs. On the mechanical side we are dealing with physical prevention of thrombosis. Over the past few years statistics have shown that the occurrence of thrombo-embolic disease has been lowered by these means, but once it has occurred they are of little use. However, since they can be used with little effort or expense they should be employed routinely. These principles are all based on the prevention of venous stasis. Early ambulation has received the most notoriety and undoubtedly has reduced the incidence of thrombo-embolic disease. However, in operative cases or diseases which cause marked and prolonged quiescence venous stasis may occur very early. Therefore exercises, massage, or pressure bandages on the lower extremities should increase the deep venous flow and so tend to prevent stasis. It requires little effort to apply these bandages to older patients pre-operatively. Massage of the thighs during the operative and anesthetic stage can be readily done two or three times an hour. Active exercise of the legs and feet can be accomplished by the patient during convalescence, and may prevent fatal thrombo-embolic disease. Venous ligation is another mechanical means of preventing as well as treating threatened embolism. As this subject has been extensively report it will not be discussed here. The reader is referr to the excellent article by Linton.[4]

There are two anticoagulant drugs which ha proved to be of great value: heparin and dicumar They both impair or prevent the coagulation blood. Heparin according to Quick[10] is thought be a glucosamine, a uronic acid and several su phuric acid groups in ester linkage. It has been us for many years in thrombo-embolic disease. T method of administration in the past has been l continuous or frequent intravenous drip. The mea of administration and the expense of the treatme have greatly curtailed its use. Recently it has be used more frequently in Pitkin's menstruum.[1,2,3,6,7] This is composed of gelatin, glacial acetic aci dextrose, and distilled water. The rate of absorptio is inversely proportional to the viscosity of th menstruum. The optimum percentage of gelatin ar dextrose were found to be 18 per cent and 8 p cent respectively.[1] At first this subcutaneous metho of administration was very painful, but recently th solution has been buffered to reduce discomfort.

There are now several commercial preparatio in ampoules of the desired dosages. They are usuall purchased as follows: 2 cc.—containing 200 mg. heparin in Pitkin's menstruum with and witho vasoconstrictors and 3 cc.—containing 300 mg. heparin in Pitkin's menstruum with or without vas constrictors. The vasoconstrictors prolong the effe of the dose. Clinical studies[7] show that the hepari effect takes place one and one half hours after ad ministration regardless of vasoconstrictors. Th effect lasts 40 hours without vasoconstrictors, an 60 hours with them. The contraindication to vas constrictors (ephedrine and epinephrine) are th usual ones such as hypertension and tachycardia.

THE MODE OF ADMINISTRATION—AND DOSAGE

Various clinicians use from 100 to 400 mg. as th initial dosage. In general it is felt that 100 to 300 mg be given to individuals less than 150 lbs., and 20 to 400 mg. to those weighing more. Loewe feel that 300 mg. will suffice for 90 per cent. The re quired dosage is given every second day. If, how ever, a blood transfusion is given an additional dos is administered immediately following it. Daily co agulation time should be done. This time should b maintained between 30 and 45 minutes or approxi mately three times normal.

After gently warming the ampoule it is shake thoroughly and the contents are drawn into a dr

rile syringe with a large bore needle. It is then ected with a twenty gauge needle into the deep cutaneous tissues, usually of the anterior or eral thigh.

The duration of the treatment in general is based the subsidence and healing of the thrombotic cess. In bed patients the treatment is continued a longer time, and usually until they have been bulatory for 2 or 3 days. The ambulatory post-erative case for whom therapy is indicated should returned to bed for 3 or 4 days, and the treatment uld further be continued 2 or 3 days after bulation. One author[13] has continued the treat-nt as long as 4 weeks in prolonged bed patients.

Dicumarol (3,3′ methylene-Bis (4 hydroxycou-rin) is the principle which causes hemorrhage in iled clover disease in animals. This drug causes a rked drop in the prothrombin time, and thus ds to prevent clot formation or propagation. Its de of administration is much simpler than heparin it is given by mouth. Also the expense of di-marol therapy is less—costing only a few cents a y—while heparin in the average case would cost 5 to $16 every other day. Dicumarol, however, quires 48 to 72 hours of administration before a erapeutic effect is established; and correspond-gly this effect—once established—takes the same gth of time to subside.

SAGE AND MODE OF ADMINISTRATION

The tablets or capsules are given by mouth daily. fore the drug is administered a prothrombin time ust be accurately done, and must be repeated ery day before subsequent dosage. This is of solute importance to prevent the serious conse-ence of hemorrhage. In our laboratory we have ed a modification of the Quick method[11] as out-ed in the recent edition of Todd and Sanford—Clinical Diagnosis by Laboratory Methods." Our dification is to agitate with a wire loop to deter-ne the end point rather than Quick's method of ting the tube. The prothrombin time should be lculated in per cent based on the normal as 100 r cent. The optimum therapeutic level should be aintained as nearly as possible between 10 per cent d 20 per cent. It is imperative that the test be ne accurately, and should be under the strict idance of an experienced technician. Most clin-ans agree that the initial dose is 200 mg., although me advocate 300 mg. As some subjects may be nsitive to the drug the smaller dose seems advis-able. After report of the prothrombin time on the second day another dose of 200 mg. may be given depending on the per cent reading which usually is normal, as only 24 hours have passed. The reading on the third day should indicate a drop, and 100 mg. is given if this is not below 50 per cent. When the prothrombin time is down to 20 per cent or some-what less it is wise either to omit one dose or give only 50 mg. Subsequently 50 or 100 mg. a day usually maintains the desired level. The drug can be administered over long periods—always with accurate laboratory control. It can usually be stopped at the time of subsidence of the thrombotic disease, or when the subject becomes ambulatory as the effect persists for two or three days.

Both heparin and dicumarol can be used together. In this way the rapid effect of the heparin can be established early while awaiting the delayed action of dicumarol. Heparin can be given for one or two doses simultaneously with dicumarol, and then dis-continued when the prothrombin time becomes therapeutically reduced. Both prothrombin and co-agulation time should be recorded while both drugs are being administered. Thus while the initial ex-pense is high, the long term treatment is inexpensive.

COUNTERACTING TREATMENT

If it is necessary to terminate the effects of these drugs rapidly—as in the occurrence of hemorrhage, hypersensitivity, or emergency operation—vitamin K and fresh blood transfusion are the most effective means. Vitamin K in doses of 50 mg. to 70 mg. is given intravenously. Whole blood or freshly cit-rated blood in small amounts (300 to 500 cc.) is recommended. The effects of heparin alone can be counteracted in two or three hours by these means; it takes considerably longer to nullify dicumarol. A prothrombin time should be done after 24 hours, then if necessary vitamin K and blood may be repeated. In persitent hemorrhage vitamin K and transfusion may be given more often. There is accumulating clinical evidence that in postpartum and postoperative patients the natural defensive co-agulating mechanism of the blood make the adminis-tration of these drugs fairly safe. Barnes and Ervin[8] administered 300 mg. of dicumarol during labor and 200 mg. the first two days post delivery with-out producing abnormal bleeding. They also gave heparin over a 24 hour period on the first or second day postpartum without complications other than hematoma in one episiotomy. However, until more evidence has been accumulated great caution should

be exercised in the use of these drugs when the possibility of hemorrhage is present.

GENERAL DISCUSSION

The method of administration and dosage already outlined is recommended in the pathological conditions discussed earlier in this article. Phlebothrombosis has been treated in large series.[1,3,5,13] According to these authors fatal pulmonary embolus has been markedly reduced or nearly eliminated.[13] The local manifestations of this disease have been reduced, and the complications of late swelling, exzema, and ulcer diminished. The same holds true for thrombophlebitis; one author[13] (who has used the intravenous drip administration of heparin) over a long period has had follow-ups of several years, and is very enthusiastic. In pulmonary embolus early and adequate anticoagulant therapy is imperative. Numerous severe and near fatal cases have been successfully treated.[13] Heparin is indicated as the initiating treatment. In cerebral thrombosis the difficulty of distinguishing it from cerebral hemorrhage has made the use of the anticoagulants rather precarious. More definite differentiation between these conditions will have to be established before this treatment can be recommended. In coronary thrombosis reports have been encouraging, but necessarily these studies will require more time for the final answer. However, the rationale of the treatment should strongly encourage its use. In this condition early anticoagulant therapy is essential, and therefore heparin is indicated at first. To date the main advantage definitely realized is the prevention of mural thrombus. It has been more difficult to evaluate the local effect in the infarcted area, but reports are promising. Several cases of rheumatic heart disease with multiple emboli, presumably from mural thrombi, were reported by Wright.[14] These were treated with dicumarol over long periods—a year or more. These subjects had no recurrence of emboli, and continued the therapy while ambulatory. The prothrombin level was determined daily for one month until the proper maintenance dose was established. This varied from 50 to 200 mg. a day. The determination of the prothrombin level was gradually decreased in frequency to once a week. In mesenteric thrombosis the use of anticoagulants must be recommended with great caution because of the danger of intestinal hemorrhage and the formation of irreversible gangrene. In frost bite the theoretical advantages of these drugs are evident, but as yet few clinical results have been reported. The early effect of the anticoagulant is imperativ therefore heparin is the drug of choice. This effe need be maintained for only 5 or 6 days. Althou I have seen no references in the literature to t use of anticoagulants in burns it seems logical th they might be effective in preventing excessive c agulation, thrombosis, and the late, ultimate destru tion of tissue. In blood vessel surgery the anticoag lants should be used with great caution. The mo meticulous hemostasis should be practiced to preve hemorrhage either from the vessels operated upon, from the surrounding tissues which were incised. traumatic cases these drugs may be useful to pr vent thrombosis, but the danger of local hemorrha should be born in mind. In peripheral arterioscle osis, diabetic gangrene, and Berger's disease som what encouraging reports occur in the literatu

CONCLUSION

The anticoagulant drugs (heparin and dicumaro have been proved to be of value in the preventic and treatment of pulmonary embolus. In numero other thrombo-embolic diseases there use is definit ly promising.

SUMMARY

1. The pathological conditions indicating the u of anticoagulants are discussed.

2. The clinical indications and prophylaxis a summarized.

3. The contraindications are enumerated.

4. The types of anticoagulants, their dosage an administration are presented.

5. The methods of counteracting the anticoagu lant drugs are given.

6. The findings in the literature are briefly di cussed.

REFERENCES

1. Loewe, L.: Am. J. Med. 3:447, 1947.
2. Loewe, L., Rosenblatt, P.: Am. J. Med. Sc. 208:53, 194
3. Allen, E. V.: J.A.M.A. 134:323, 1947.
4. Linton, R. R.: Med. Clin. N. Am. 30:1068, 1946.
5. Evans, J. R., Dee, J. F.: N. E. Med. 238:1, 1948.
6. Lange, K., Loewe, L.: S. G. and O. 82:256, 1946.
7. Evans, J. A., Boller, R. J.: J.A.M.A. 131:879, 1946.
8. Barnes, A. C., Ervin, H K.: S. G and O 83:528, 1946.
9. Falk, O. P. J.: J.A.M.A. 134:491, 1947.
10. Quick, A. J.: Physio. Rev. 24:297, 1944.
11. Quick, A. J.: A. M. J. Clin. Path. 10:222, 1940.
12. Todd and Sanford: Clinical Diagnosis by Laborato Methods.
13. Murray, G.: Am. Med. J. 3:468, 1947.
14. Wright. I. S.: Conn. State Med. J. 12:3, 1948.

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STATISTICAL REPORT OF THE SECRETARY

MEMBERSHIP

AIRFIELD COUNTY

Membership—April 1, 1947		509
New Members		70
		579
Died	6	
Lost by resignation, transfer, dropped non-payment	7	13
Membership—April 1, 1948		566

ARTFORD COUNTY

Membership—April 1, 1947		661
New Members		53
		714
Died	11	
Lost by resignation, transfer, dropped non-payment	12	23
Membership—April 1, 1948		691

ITCHFIELD COUNTY

Membership—April 1, 1947		92
New Members		11
		103
Died	2	
Lost by resignation, transfer, dropped non-payment	1	3
Membership—April 1, 1948		100

MIDDLESEX COUNTY

Membership—April 1, 1947		80
New Members		6
		86
Died	0	
Lost by resignation, transfer, dropped non-payment	1	1
Membership—April 1, 1948		85

NEW HAVEN COUNTY

Membership—April 1, 1947		669
New Members		64
		733
Died	10	
Lost by resignation, transfer, dropped non-payment	20	30
Membership—April 1, 1948		703

NEW LONDON COUNTY

Membership—April 1, 1947		127
New Members		20
		147
Died	3	
Lost by resignation, transfer, dropped non-payment	9	12
Membership—April 1, 1948		135

TOLLAND COUNTY

Membership—April 1, 1947		19
New Members		1
		20
Died	0	
Lost by resignation, transfer, dropped non-payment	2	2
Membership—April 1, 1948		18

WINDHAM COUNTY

Membership, April 1, 1947		45
New Members		4
		49
Died	0	
Lost by resignation, transfer, dropped non-payment	1	1
Membership—April 1, 1948		48

TOTALS

Fairfield	566
Hartford	691
Litchfield	100
Middlesex	85
New Haven	705
New London	135
Tolland	17
Windham	48
Totals	2,347
Associate Members	9
	2,356
Net gain for year	145

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MMITTEE ON MILITARY HISTORY OF THE SOCIETY

Committee discontinued

MMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

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Another Kind of Health Legislation

On February 24, 1947, Senator Lodge of Massa-usetts introduced S678 into the Congress. At that ne Senator Lodge had printed in the Congressional ecord a statement that the Bill would provide a w drugs and services including sulfa drugs, in-lin, liver extract, mercury diuretics, endocrine oducts, vitamin preparations, typhoid vaccine, nicillin and streptomycin. His statement also dicated that the use of respirators and x-ray serv-es would be made available free to needy persons d at a minimum cost to other persons. The Bill as amended on May 16, 1947 and the amendment in the nature of a substitute. This legislation will ake available to the several states federal funds annually in an amount yet to be determined to enable them to provide or to assist in providing certain medical services and medicines which are standardized in their nature "but, which because of their high costs, are not used in many cases in which their use is desirable. This amended or substitute Bill would make them available "free to such persons as may require them."

Section 706 (a) defines what is meant by the term "medical aid." It is defined to mean x-ray services, laboratory diagnostic services, respirators, and any drug which is of substantial, accepted, and specific value in the treatment or prevention of pneumonia, streptococcus infection, diabetes, pernicious anemia and other anemias, congestive heart failure, glandular and nervous disorders, nutritional deficiency, typhoid fever and such other infectious or chronic diseases as the Surgeon General of the Public Health Service may from time to time prescribe.

This legislation represents an approach to health problems somewhat different from the approach suggested by other bills pending before the Senate Committee on Labor and Public Welfare. Whether or not this different approach is administratively feasible on a federal and on a state level will require much consideration. The Committee will first wish to determine, too, whether the medical aid contemplated by the legislation should be offered free to everyone despite the financial ability of many persons to purchase the drugs and the services for themselves.

The bill is not entirely clear as to whether the providing of this medical aid includes the cost of administration, such as the fees to be charged by physicians, the cost of any specific apparatus such as hypodermic syringes, and so on. By way of illustration, the actual cost of an x-ray film—the physical property—in the usual case will probably not exceed $1. The cost of a roentgenologic diagnosis is due in the main to the costly equipment that is necessary to enable the roentgenologist to process the film and the cost of the services of the roentgenologist in making an adequate interpretation of the film and in prescribing treatment based on that interpretation.

State plans under which medical aid is to be furnished must be approved by the Surgeon General but the bill does not specifically provide for a review of a determination made by him. It would seem desirable to guarantee such a review, either by the courts or by an advisory committee or council.

Dr. B. Austin Cheney Memorial Gift



B. Austin Cheney, M.D.

A gift in memory of Dr. B. Austin Cheney, for many years president of the Board of Directors of the Grace Hospital in New Haven, has been announced by the Trustees of the Society's Building Fund. Dr. Cheney died in October 1945, having served as president of the hospital's directing group since early in 1929.

Dr. D. Chester Brown Memorial Gift

A memorial gift of several thousand dollars has been contributed to the Society's building fund by the friends and former patients of Dr. D. Chester Brown, a practicing physician in Danbury for many years until his death in 1943.

Dr. Brown was president of the State Medical Society in 1913, and prior to that time had been president of the Fairfield County Medical Association. He was a member of the Board of Trustees of the American Medical Association from 1918 to 1930.

Dr. Brown was born at Norfolk, Virginia on November 16, 1863. He received his academic degree at Yale University, and graduated from th Yale University School of Medicine in 1884. Fo lowing completion of his internship at the Hartfor Hospital, he continued postgraduate studies at th University of Prague and the University of Berli

Upon his return to this country, Dr. Brown bega the practice of medicine and surgery in Danbury and for more than half a century was very activ in professional and civic enterprises in that com munity. His generous devotion of time and effo to the furtherance of medical progress was attestec by the many honors he received during his caree

Dr. Brown was a member of the New Yor Academy of Medicine, a Fellow of the America College of Surgeons, and a Fellow of the America Medical Association. He was the first chairman o the Connecticut Clinical Congress.

During the first World War he entered the serv ice as a captain and a year later was promoted to th rank of major and assigned to the medical sectio of the Provost Marshal General's Office in Wash ingtin, D. C. Although advanced years barred hir from active duty in World War II, he gave valuabl



David Chester Brown, M.D.

rvice in civilian defense, and furnished the driving rce for its organization in Danbury. He also con- buted a great deal of time as medical advisor for e Red Cross.

He was a member of the First Congregational urch, the Mayflower Society, and various asonic groups, including the Crusader Command- y, Knights Templar, and Pyramid Temple, Nobles the Mystic Shrine of Bridgeport.

Awards by Life Insurance Research Fund

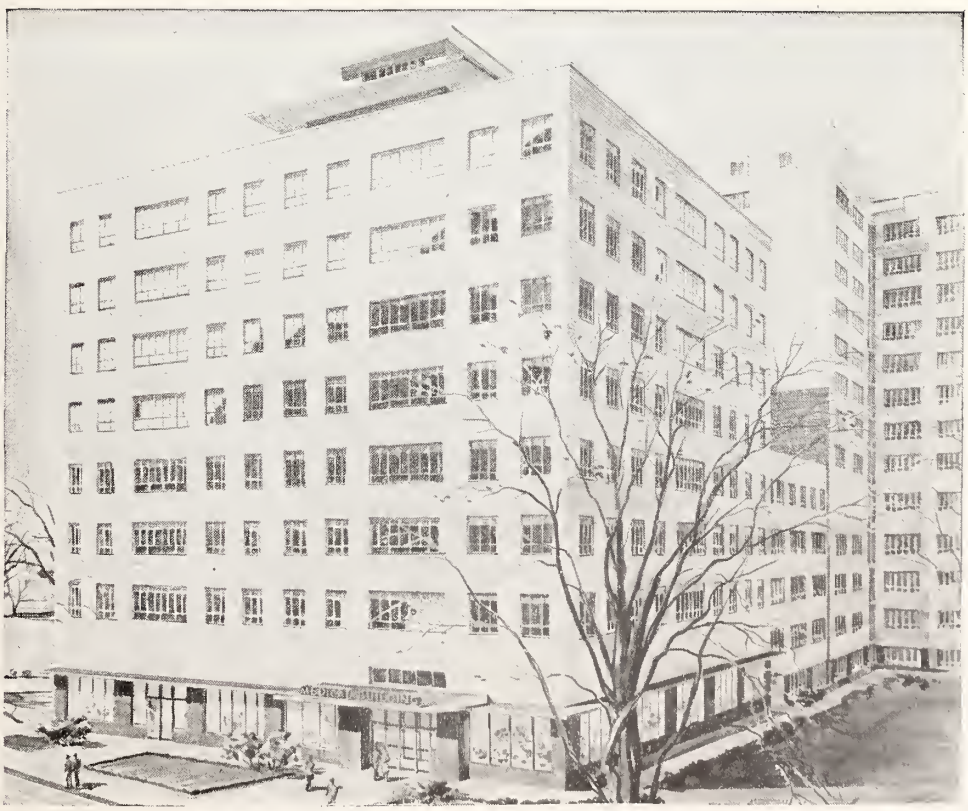
The Life Insurance Research Fund announced in arch a postgraduate research fellowship to Robert arail, M.D., of Minneapolis to work under the pervision of John P. Peters at the Yale University hool of Medicine. This fellowship carries a stipend tween $2,500 and $4,000. The same Fund also nounced a grant-in-aid to Yale University of ,675 for research by William T. Salter on the emical control of digitalis therapy.

The Fund is supported by 149 life insurance com- nies and is administered through a board of rectors representing the life insurance business d an advisory council of medical research experts, e latter headed by Francis G. Blake, Sterling Professor of Medicine at Yale. Scientific director of the Fund is Francis R. Dieuaide, clinical professor of medicine on the staff of the College of Physicians and Surgeons of Columbia University.

A Connecticut Physician in 19th Century Texas

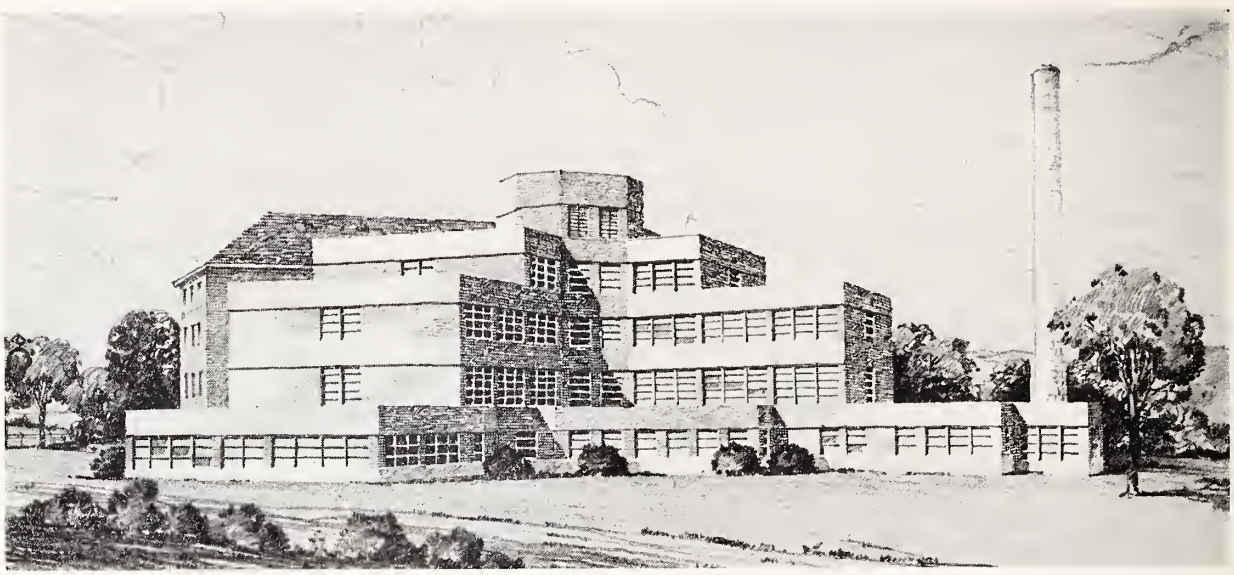
"Ashbel Smith, M.D., 1805-1886: Pioneer Educator in Texas" is the title of a contribution by Chauncey D. Leake published in *The Yale Journal of Biology and Medicine*, January 1948. Dr. Ashbel Smith was a native of Hartford, a graduate of Yale College and four years later of the Medical Institute. Arriving in Texas at the close of its war for independence, he became in succession the first Surgeon General of the Republic of Texas, Secretary of State, the first Minister to England and France, a member of the Texas House of Representatives following admission to the Union, a member of the Texas Senate, a leader in the formation of the Texas State Medical Society, Dean of the first medical school in Texas at Galveston, and Chairman of the Board of Regents of the University of Texas.

As physician, statesman, and educator, Ashbel Smith was truly a remarkable man.



Medical Building of New Hartford Hospital

THE GREATER DAY KIMBALL HOSPITAL



A $600,000 program for the expansion and modernization of Day Kimball Hospital of Putnam, Connecticut, is under way. Shown in the architects' drawing of the enlarged hospital, as seen from the rear, is the fireproof Y-shaped structure that will replace the present wooden South Wing. Modern surgical and x-ray equipment will be added, patients' accommodations for adults and children will be increased from 80 to 110 beds and nurseries for 27 newborn infants will replace the present 18-bassinet nursery.

The experience at Day Kimball Hospital is fairly typical of the increasing dependence on hospitals in smaller communites, away from the big cities. Patients and physicians are demanding that the latest techniques of treatment and diagnosis be made available locally to avoid the delays and additional costs involved in going outside the community for hospital care, and to supply to doctors the complex equipment that is essential for the practice of modern medicine.

More than 30,000 people in the Putnam-Danielson and surrounding areas look to Day Kimball Hospital for their health protection. In this part of the state where textile mills abound, hospitalization insurance is on the increase and every year the number of both in-patients and out-patients grows. As the trend accelerated, periodic expansion and modernization became necessary and the Hospital has come a long way from the original little structure of 1896.

The Hospital accommodates normally 80 adult and child patients and 18 newborn infants. In 1947 the average daily census was 81, including newborn. Obviously this meant that at peak times the hospital could not accommodate immediately all who needed care. As a matter of fact there always is a waiting list of patients requiring "non emergency" surgery. This throws squarely on the physician the responsibility of deciding whether or not a patient can safely wait for weeks, or possibly months, b fore treatment is available.

Overcrowding is not the only problem. One win a frame structure, dates back many years. It is u attractive in appearance and it could be a fire hazar There are insufficient facilities for maternit patients. One delivery room and one labor roo often create a difficult traffic problem. X-ray equip ment is obsolete and extremely limited. The eme gency department is too far from the ambulanc entrance and the emergency examining and trea ment rooms are too small. There is no meeting roo for the staff and physicians must sit around a labora tory table to discuss their findings and problems.

Physicians and laymen alike in the area, recog nizing the potential health hazard caused by th lack of adequate hospital facilities, have undertake a program of further expanding and modernizin Day Kimball Hospital so that it can better serve th community today and meet the even greater de mands of the future. Architects' plans were draw with the advice of and in cooperation with sta physicians and hospital authorities and it was est mated that approximately $600,000 would be neede to complete the project.

It was decided to present the program to th people of the area and assemble a $300,000 buildin fund through public subscription. The Hospit

has in hand $150,000 from previous contributors, and application has been made for $150,000 of federal funds in accordance with the provisions of the Hill-Burton Act.

The greater Day Kimball Hospital will solve most of the problems that confront it. The wooden South Wing will be torn down to make way for a three-story, fireproof Y-shaped structure that will house a completely modern surgical department of three operating rooms, an anesthesia room, doctors' lounge and sterilizing equipment. Also in this building there will be accommodations for private and semi-private surgical, medical and obstetrical patients, as well as kitchen and dining units, laundry, boiler room and supply rooms.

Present facilities will undergo major reconstruction. The x-ray department, now seriously inadequate, will be transferred to the ground floor of the central wing where sufficient space will be available to install more modern radiographic and fluoroscopic equipment. The emergency and out-patients departments also will be greatly expanded.

Nursery accommodations will be increased and modernized, with a separate cubicle for each bassinet. In the pediatrics department the number of beds will be doubled, and the department will be so arranged that it can be isolated from the rest of the hospital in the event of the outbreak of a contagious disease. The present surgical department will be converted at slight cost into a well equipped obstetrical department, with two delivery rooms and a labor room.

The expanded Hospital will accommodate 110 adult and child patients and 27 newborn infants.

Realizing the need for a free exchange of ideas among physicians, hospital authorities have included in the plans a clinical meeting room. Here doctors from all parts of the service area will gather to discuss new techniques of medicine and consider common problems.

This clinical meeting room is an important addition to Day Kimball Hospital, and the staff doctors have undertaken to subscribe the $36,000 required for its construction. At this writing 11 doctors have already subscribed $26,000 and by the time this article is in print it is expected the full amount will be available.

Lay and professional leaders throughout the area are working together to complete this program quickly and successfully. Only when every brick has been laid and the last piece of equipment put in place can it be said that faith has been kept with those who look to Day Kimball Hospital for the protection of their health.

CONFERENCE OF COUNTY AND STATE OFFICERS

The annual Conference of County and State Officers sponsored by the State Medical Society in New Haven, Thursday, March 18, proved the most successful event of its kind in the Society's history. James R. Miller, president of the Society, opened the conference, and presided at the afternoon session in the auditorium of the New Haven Medical Association Library.

The importance of county medical associations in relation to the State Medical Society and the American Medical Association was discussed by Creighton Barker, the Society's executive secretary. He emphasized that the initiative for action in many medical affairs rests with the county organizations.

In discussing the operation of the prepaid medical care plan of the United Medical Service, Dr. Frederic H. Elliott, the organization's director of medical services, explained that the most significant feature of the service is its complete operation by physicians. Originally financed by a small group of physicians through individual subscriptions of $25, the service now has its own accumulated capital of more than 1½ million dollars.

The objectives and future development of the Society's plans for student membership were explained by Herbert Thoms, member of the governing council. Other discussions during the afternoon session included problems of dues collection by Miss Grace Mooney, assistant executive secretary of the Society, and public relations projects by James G. Burch, director of the public relations program.

Following a dinner at 7 o'clock round table discussions were led by Thomas P. Murdock, chairman of the Council of the Society. Participants included the secretaries of county medical associations—Courtney C. Bishop, New Haven; George A. Buckhout, Fairfield; Thomas J. Danaher, Litchfield; and

W. Holbrook Lowell, Jr., Hartford. Questions discussed concerned the transaction of business by county secretaries, enrollment of new members, formulation of programs for county meetings, and the provision of information for county association delegates prior to convening of the House of Delegates. Attendance at the conference numbered 27 county and state officers and included the following: Thomas P. Murdock, W. M. Shepard, Karl Phillips, George H. Gildersleeve, Thomas J. Danaher, Frank L. Polito, Cole B. Gibson, Courtney C. Bishop, Clifford D. Moore, Berkley M. Parmelee, Oliver L. Stringfield, J. Grady Booe, Norman E. Gissler, Frank H. Couch, C. T. Schechtman, W. Holbrook Lowell, Jr., Louis P. Hastings, Samuel C. Harvey, Herbert Thoms, Joseph Howard, Thomas Soltz, Alfred Labensky, Charles G. Barnum, Arthur B. Landry, Stanley B. Weld, Creighton Barker, James G. Burch, Grace Mooney.

T.B. Society To Recruit Nurses

At the semi-annual meeting of the Connecticut Tuberculosis Association held in Hartford on March 23, President William H. Morriss was empowered to appoint a committee to study the problem of the shortage of nurses. This committee at the request of Joseph I. Linde, chairman of the State Tuberculosis Commission, will assist in carrying on a campaign for the recruitment of nurses.

Kirby S. Howlett, assistant medical director of Laurel Heights Sanatorium, was the guest speaker at this same meeting. Dr. Howlett presented briefly his experiences with the use of streptomycin in the treatment of tuberculosis. Since November 1946 one of the eight projects for studying the use of this new drug has been carried on at Laurel Heights Sanatorium in Shelton in conjunction with Yale University School of Medicine. In January 1947 any suitable case in Connecticut sanatoria was made available for the use of streptomycin. The toxic effects of this drug include a disturbance in the vestibular portion of the ear producing vertigo. This has been reduced by using smaller doses. Some patients become resistant to streptomycin and in such individuals it can never be used a second time.

Dr. Howlett emphasized the fact that streptomycin is not an eradicator of tuberculosis but a suppressor. This means, of course, that all other methods of treatment must be utilized as well. Streptomycin is particularly valuable when used in connection with lung surgery. Also the timing o the use of it is important.

Streptomycin should never be used except whe really needed, Dr. Howlett pointed out. It has aide in the treatment of tuberculosis but at the same tim has made such treatment more complex. For th purposes of closer observation and study as well a because of the possibility of toxic effects, strepto mycin should be used in the sanatorium, not in th home.

Dr. Blake Appointed Chairman of Nationa Board

The appointment of Dr. Francis G. Blake, Sterlin professor of medicine at the Yale University Schoo of Medicine, as chairman of the Committee o Medical Science of the Research and Developmen Board of the National Military Establishment wa recently announced by Vannevar Bush, boar chairman.

The committee is concerned with the progress o medical research in the armed forces, and its head quarters have been established in the Pentago Building, Washington, D. C.

Dr. Blake is physician-in-chief, Grace-New Have Community Hospital University Service. He wa dean of the Yale University School of Medicin from 1941 to 1947, and acting dean from 1940 t 1941. His medical degree was received at the Har vard University Medical School in 1913, and hi academic degree at Dartmouth College in 1908.

Health of Arc Welders

The Industrial Hygiene Division of the U. S Public Health Service has released a bulletin entitle "Health of Arc Welders in Steel Ship Construc tion." The bulletin presents the results of investiga tions relating to the health of shipyard worker carried out during 1944 in 7 shipyards located o the Atlantic, the Gulf and the Pacific coasts. Th study was made by the Industrial Hygiene Divisio of USPHS in cooperation with the U. S. Maritim Commission and the U. S. Navy. It was initiated i 1943 because of increasing complaints of respirator illness from shipyard workers. Although the study did not reveal any major health hazards, the finding will be of great assistance to physicians, engineers and compensation authorities.

Single copies may be obtained from the U. S Public Health Service, Washington 25, D. C.

CONNECTICUT CANCER SOCIETY

First Cancer Conference in Connecticut

The strong interest of Connecticut physicians in ıe cancer problem was clearly demonstrated by the ıuge attendance of doctors from all parts of the ıate at the State's first Cancer Conference for 'hysicians, held all day, Thursday, March 25, in Jew Haven. More than 400 doctors were present at he discussions, many of them in attendance during he entire period of the sessions. State medical lead- rs agreed that the event was one of the most uccessful ever sponsored for physicians in Con- ecticut. It was presented by the Connecticut Cancer Society, with the cooperation of the Con- ecticut State Medical Society. Officials of both rganizations expressed the hope that the event night be made an annual one.

Keynoting the panel addresses of speakers in both he morning and afternoon discussions was the asser- ion that alertness by doctors, in the course of hysical examinations of patients, represents one f the foremost factors in discerning the presence f cancer. Virtually every speaker discussing a articular form of cancer told how long neglected reatment of cancer can encroach upon and involve ital structures of the body and endanger the entire ystem. Modern techniques in both the diagnosis nd treatment of each type of cancer were described y each of the cancer specialists.

Pointing out that statistics of the Division of Can- er Research reveal a jump in the state's cancer nortality rate, from 111.6 per 100,000 in 1935 to 19.1 in 1946, Dr. James R. Miller, president of he State Medical Society, said that the state's cancer rogram is benefitting from the cooperative effort f the Connecticut Cancer Society, the Connecticut State Medical Society and the State Department of Health.

Also speaking during the morning discussions, Dr. Creighton Barker, president of the Connecticut Cancer Society, described the numerous cancer facilities in the state performing research, rendering clinical assistance and aiding in cancer treatment. Dr. Barker referred to the family physician as "the first line of defense." "It is he," Dr. Barker said, "who sees the most people and who has the best opportunity and broadest responsibility to give service and information which should lead to diagnosis."

The principal speaker at the evening session was Dr. Charles S. Cameron, head of the American Cancer Society's medical and research department, who pointed out that Connecticut was second among the states in the country in providing clinical facilities for treating cancer. He also praised the leadership of Yale in establishing a department of oncology to coordinate the teaching of cancer subjects.

The evening session, which was open to the public, contained a demonstration of a Geiger Counter by Dr. Ernest C. Pollard of Yale.

Panel speakers included: Dr. Jack Wolf, New York Skin and Cancer Hospital; Dr. Wyland F. Leadbetter, Tufts Medical School; Dr. Leland S. McKittrick, New England Deaconess Hospital; Dr. John C. Leonard, Hartford Hospital; Dr. Edward J. Ottenheimer, Windham Community Memorial Hospital; Dr. Gustaf E. Lindskog, Yale School of Medicine; Dr. Ashley W. Oughterson, Yale School of Medicine and Dr. J. Vincent Meigs, Massachusetts General Hospital.

Dr. Donald A. Bristoll of New Britain was chairman of the committee that planned the event. Other members of his committee were: Dr. Richard I. Barstow, Norfolk; Dr. Harold A. Bergendahl, Norwich; Dr. Alfred L. Burgdorf, Hartford; Dr. Richard F. Grant, Cromwell; Dr. Homer W. Grimm, Bridgeport; Dr. Samuel C. Harvey, New Haven; Dr. John C. Leonard, Hartford; and Edwin R. Meiss, director of the Connecticut Cancer Society.

Four-Point Cancer Program Disclosed by Atomic Commission

The Atomic Energy Commission has disclosed long awaited plans for expending the $5,000,000 which it received from Congress last July for cancer research.

They envision a four-point program: (1) provision of free radioisotopes to qualified handlers in approved research and treatment institutions; (2) financial support of research projects in hospitals,

clinics and universities; (3) establishment of cancer investigation facilities, and (4) continued aid to the Committee on Atomic Casualties (National Research Council) investigating long term effects on survivors of the Nagasaki and Hiroshima bomb explosions.

Free radioisotope distribution, beginning April 1, will be limited for the time being to Iodine-131, Phosphorus-32 and Sodium-24, the announcement said. There will be no charges, except for handling and transportation, and applications will be processed at AEC's isotopes branch, Oak Ridge, Tenn., as heretofore.

AEC's own research laboratories in cancer are being set up at Oak Ridge Hospital, Brookhaven (N. Y.), Argonne (Chicago) National Laboratories, and Los Alamos Laboratory (N. M.), with their facilities being made available to medical schools, clinics and hospitals in each region.

Federal Funds for Cancer Program

The National Advisory Council of the National Cancer Institute, in making recommendations for the construction of clinical and laboratory research facilities, has allocated $250,000 to Yale University for an animal laboratory building. This is part of the $8,000,000 approved by Congress for construction grants in the cancer research program. $435,706 is to be distributed to medical and dental schools by the Institute for cancer teaching programs. This brings the total thus far given to medical and dental schools to $1,389,573.

Yale University has also been awarded by the National Cancer Institute a grant of $7,668 for "analytical cytology as applied to the study of pathology."

Congenital Malformations from German Measles

The web of proof that German measles during the first 3 months of pregnancy may cause congenital malformations is being woven together. Another strand in this web is the first quarterly report of the committee appointed by the National Society for the Prevention of Blindness and the American Academy of Pediatrics and headed by Dr. Herbert C. Miller of the University of Kansas Hospitals.

In the report of 132 mothers who had Germa measles during the first trimester of pregnancy the were 18 babies reported as normal. Sixty-two babi weighed less than 6 pounds at birth. Seventy-s babies had congenital cataracts. Thirty-five we found to be partially or completely deaf. Twenty two babies were microcephalic and 46 were me tally retarded. Malformations of the heart we diagnosed in 67 babies, but none were diagnosed "blue babies." Disturbances of the eye, other tha congenital cataracts, were observed in 13 babie including congenital glaucoma 3, microphthalm 5, nystagmus 2, chorioretinitis 2, and strabismus Dental defects were found in 2 children, one whom had congenital absence of some of the teet and the other of whom had a diffuse enamel defec Hypospadias was observed in 4 children and in guinal hernias in 4. Malformations of the extremitie including club foot 1, webbing of the fingers were found in 3 babies. Cleft palate was diagnose in 3 children and harelip in 1. Micrognathia wa diagnosed in 1 child. There was 1 cretin, 1 mon golian idiot, 1 child with enlargement of 1 ear, an other with enlargement of 1 breast, 1 child with defect of the 4th rib.

Other infections than German measles were re ported, but the data is too scanty except perhaps i respect to infectious mononucleosis. There hav been 4 mothers who contracted infectious mononu cleosis during the first 10 weeks of pregnancy an 3 of the 4 babies had malformations of the heart Two of the 3 babies died in the first 2 weeks an post-mortem examination revealed extensive con genital malformations. One of the 3 babies wit heart trouble had congenital cataracts. No othe malformations were found. The 4th baby has re mained entirely well.

In order to make this study of increasing signifi cance, the committee needs more case material especially cases of German measles in expectan mothers *where the diagnosis has been made by physician.*

Physicians who have such information are re quested to write to Dr. Herbert C. Miller, Univer sity of Kansas Hospitals, Kansas City, Kansas, for questionnaire.

Committee on Public Policy and Legislation
irfield County, Charles H. Sprague, Bridgeport
artford County, Benjamin B. Robbins, Bristol
tchfield County, W. Bradford Walker, Cornwall
iddlesex County, Richard H. Grant, Cromwell
ew London County, Edmund L. Douglass, *Chairman*
Groton
ew Haven County, Charles T. Flynn, New Haven
olland County, Leonard W. Levine, Ellington
Vindham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

Council on National Emergency Medical Service

The first general conference of the Council on ational Emergency Medical Service was held at e headquarters of the American Medical Associa- on, Chicago, April 5, 1948. The Connecticut State ledical Society was represented by its Executive ecretary, Creighton Barker. Thomas P. Murdock so attended as the representative of the American ledical Association Committee to Study Nursing roblems. Delegates from forty-one state medical ocieties and a number of other groups related to edical care, hospitalization, and medical education ere present. Attendance was by invitation only nd the sessions were closed to others.

The conference was presided over by James argent, Milwaukee. Other members of the Council, hich was appointed following the Annual Meeting f the American Medical Association in Jan. 1948, e Richard L. Meiling, secretary, Columbus, Ohio; V. McK. Craig, Rochester, Minnesota; Harold S.)iehl, Minneapolis; Perrin H. Long, Baltimore; Harold C. Lueth, Omaha; Stafford Warren, Los ngeles; and ex officio President Edward L. Bortz, hiladelphia; George F. Lull, Chicago. They are all eteran medical officers of World War II except)r. Diehl, who was a member of the Directing oard of the Procurement and Assignment Service.

A note of stern reality pervaded the conference nd all present seemed filled with awe that the coun- ry was for the third time in a lifetime facing the ossibility of another global war. Subjects on the rogram included illustrated discussion of the poten- ial and horrors of atomic warfare by Dr. Warren; levelopments in chemical warfare by Captain George M. Lyon, MC-USNR; psychologic war- are by Hans H. F. Reese, University of Wisconsin, nd the activities of the National Academy of cience by Herman S. Wigodsky, professional associate of the Committee on Atomic Casualties. The afternoon session on the fifth included the report of the Society of Medical Consultants of World War II by Perrin Long; the part of the American National Red Cross in wartime emergencies and the development of a National Blood Bank by G. Foard McGinnes, vice-president for Health Services, American National Red Cross; and the place of the Veterans Administration in a national emergency by James B. Mason, chairman of the Professional Standards Board of the Veterans Administration. Lt. Col. Barnet W. Beers of the Committee on Civilian Components, Office of the Secretary of Defense, explained the newly created Department of Civilian Defense in the Office of the Secretary of Defense, Mr. Forrestal. This is a new agency which parallels and has the same standing as the Department of the Army, Department of the Navy and the Department of the Air Force.

On April 6, there was an all morning panel discussion on medical, health, and sanitary problems of military establishments in the event of a national emergency. It is safe to say that there were few in attendance who were not amazed by the extent of the development of plans for the third world war. In this panel discussion, the Department of the Army was represented by Col. William L. Wilson, MC; Department of the Navy, Rear Admiral Morton D. Willcutts, MC; Department of the Air Force, Col. John M. Hargreaves, MC; The United States Public Health Service by Dr. John Alsever; and Office of Selective Service, Col. Richard H. Eanes, M.D.

This symposium brought out many interesting suggestions and some formal proposals. Admiral Willcutts proposed that the Council on National Emergency Medical Service become the Medical Section of the National Security Resources Board. The future plans for the reestablishment of selective service were outlined in detail by Col. Eanes

and he also explained the provisions in legislation now pending for a new selective service. The medical functions of selective service will operate in about the same manner as formerly including the services of physicians on a vountary basis. The pending legislation includes the provision that physicians, dentists, and veterinarians can be inducted into the service, "in such classifications and in accordance with such priority as the President shall determine." The deferment of physicians and other professionals was discussed at length and there was general agreement on the necessity for the establishment of a classification board similar to the late Procurement and Assignment Service.

Col. Hargreaves of the Air Force made pointed comment on the wastage of medical manpower during World War II and outlined some plans being developed in the Air Force to preclude this inefficiency in the event of another war.

All of the services reported that they were substantially below their authorized strength and were in need of more men. Admiral Willcutts discussed the status and provision for discharge for physicians now on duty with the Navy who had been trained under the V-12 program.

Throughout the conference, the importance of state medical society participation in the new war plans was emphasized. The formation of state committees on civilian defense and protection was urged as was physician participation in the operation of the selective service and preliminary planning and inventory of medical personnel and hospital fa ities in each state.

Those who remember the confused and hec days late in 1941 and through the spring of 1 cannot help but be impressed by the grim ord liness of war planning now and the realization the part of the armed forces of the necessity early counsel from informed civilians.

A few days after the Chicago Conference t State Society sent the following letter to all Co necticut representatives in the Congress, it reach them on the day that hearings on the Andrews b opened.

"The Connecticut State Medical Society wishes direct your especial attention and opposition to t provision in the Andrews bill to reactivate t Selective Service which authorizes special calls f physicians, dentists and veterinarians up to fort five years of age.

"Our opposition to this proposal is on the grou that it is unnecessary in view of the record medicine in World War II in supplying need medical personnel. Further, we believe it is d criminatory in that other needed scientific a technical personnel is not subject to similar call a that it reflects on the patriotism of physicians b inferring they will not volunteer in our country defense.

"You are respectfully urged to seek the deleti of this section of the bill."

NEWS FROM WASHINGTON

New Bills Introduced

S2269 by Mr. Revercomb, of West Virginia, March 4. A bill to amend title II of the Social Security Act in order to reduce the qualifying age for Old-Age and Survivors Insurance benefits to sixty and broaden the Old-Age and Survivors Insurance system to include benefits on account of disability.

Referred to the Committee on Finance.

Comment: The measure amends the Old-Age and Survivors Insurance system, lowering the age of beneficiaries from 65 to 60, and broadening the system to include benefits on account of total disability. The term "total disability" is defined to mean "total inability to work by reason of illne injury or other impairment. An individual is total unable to work when he is afflicted with an impai ment which renders it impossible for him to enga in any substantial gainful work as defined in regul tions of the Administrator." In such instances, t Administrator, by regulation can provide for exa ination of individuals in order to determine t entitlement to benefits. In accordance with regul tions that the Administrator may prescribe, he m find that, if the individual refuses to submit to su an examination, the individual is not disabled or previously existing disability had ceased. The A ministrator may also make provision to furni medical, surgical, institutional, rehabilitation

her services to individuals entitled to receive nefits, if he believes that these services may enable e beneficiary to return to gainful work.

HR5678 by Mr. Priest, of Tennessee, March 3. bill to assist the States in the development and aintenance of local public health units, and for her purposes.

Referred to the Committee on Interstate and oriegn Commerce.

Comment: This measure is identical with S2189 altonstall) and HR5644 (Dolliver).

HYSICALLY HANDICAPPED SURVEY

S2319 by Mr. Johnson, of Colorado, March 15. bill to provide for a survey of physically handipped citizens.

Referred to the Committee on Post Office and ivil Service.

Comment: Senator Johnson stated that the purose of the survey is to determine through a census, he number, age, location and type of physically andicapped citizens so as to "have definite knowldge and facts upon which to base legislative and ther programs in their interest." For the purpose f this survey, a physically handicapped citizen neans "any citizen who, because of (1) congenital leformity, (2) injury, or (3) disease, is substanially handicapped in obtaining employment or in elf employment." There is authorized to be appropriated $5,000,000 to carry out the purposes of this Act.

MEDICAL SERVICE CORPS

S2366 by Mr. Gurney, South Dakota, March 22 (introduced by request. HR5983 by Mr. Andrews, of New York, March 24.

Referred to the Committees on Armed Services.

The bill authorizes the appointment to the Navy Medical Service Corps, direct from civil life, of pharmacists, bacteriologists, biochemists, and other allied scientists, in order to bring the Medical Service Corps up to its authorized strength.

HOSPITAL CONSTRUCTION

S2374 by Mr. O'Mahoney (for himself and Mr. Robertson of Wyoming), March 23. A bill to amend title VI of the Public Health Service Act so as to extend the time within which States may take legislative action necessary to qualify for receiving Federal aid in the construction of hospitals under such title.

Referred to the Committee on Labor and Public Welfare.

Comment: This measure amends the Hospital Construction Act to extend the time, from July 1, 1948 to July 1, 1949, within which the States may take legislative action to qualify to receive Federal aid, under the Hospital Construction Act.

NEW SCIENCE BILL

S2385 by Mr. Smith, of New Jersey (for himself, Mr. Cordon, Mr. Revercomb, Mr. Saltonstall, Mr. Thomas of Utah, Mr. Kilgore, Mr. Magnuson, and Mr. Fulbright), introduced March 25.

HR6007 by Mr. Wolverton, of New Jersey, March 25. A bill to promote the progress of science; to advance the national health, prosperity, and welfare; to secure the national defense; and for other purposes.

Referred to the Committee on Labor and Public Welfare in the Senate and to the Committe on Interstate and Foreign Commerce in the House.

Comment: The new bill provides for the objections raised by the President when he vetoed its predecessor. The principal variations are as follows: The President, with the approval of the Senate, will nominate the members of the Foundation after receiving suggestions from the National Academy of Sciences, the Association of Land Grant Colleges and Universities, the National Association of State Universities, the Association of American Colleges, or by others. A member having served two terms or twelve years, under the new bill, may be eligible for reappointment after an interim of two years. The Foundation shall render an annual report to the Congress instead of to the President. The director will be appointed by the President with the advice and consent of the Senate, and becomes a non voting member of the executive committee, composed of nine others. The term of office of each member of the executive committee is two years, with a maximum of six years. In the previous bill, the director was to be appointed by the Foundation. The salary is increased from $12,000 to $15,000. The new bill contains no division on National Defense. The Foundation is expressly forbidden to support any research or development activity in the field of atomic energy. Among the divisions authorized are: a division of Medical Research and a division of Biological Sciences; and provision is made for the Foundation to establish for such time as it may determine, a special commission on cancer,

on heart and intravascular diseases, and on poliomyelitis and other degenerative diseases.

ATOMIC ENERGY COMMISSION

S2388 by Mr. Wherry, of Nebraska, March 25. A bill to transfer the functions of the Atomic Energy Commission to the Department of the Army.

Referred to the Joint Committee on Atomic Energy.

Comment: The measure seeks to transfer the functions, powers, and duties of the Atomic Energy Commission to the Department of the Army, and to be administered by the Secretary of the Army under the general supervision of the Secretary of Defense.

Action on Bills

CABINET DEPARTMENT

S140. Was reached again on the Senate calendar, March 15, and was passed over.

AID TO EDUCATION

S472. The Senate began debate on the proposed law, March 23, 1948. Passed the Senate April 1.

NURSE RETIREMENT

HR 4090. Passed the House March 15.

X-RAY FILM

HR4739. Passed the House February 24. Passed the Senate March 29. Gone to the President.

WORLD HEALTH ORGANIZATION

A resolution (SJRes.98) authorizing that the United States become a member of the World Health Organization passed the Senate July 7. A similar resolution (HJRes.161) in the House was reported by the Committee on Foreign Affairs, but has been tabled for the time, by the committee on Rules.

SOUTHERN EDUCATION AUTHORITY

HJRes.334. A resolution authorizing the creation of an interstate educational authority was reported in the House of Representatives March 16.

S472. Passed the Senate. This bill provides Federal subsidies to assist States in financing a minimum foundation education program of public elementary and secondary schools. The funds can be used for any purpose for which the State spends its own school funds. The bill will now be referred to the House, where similar bills have been considered l appropriate committees, but none has been report out.

HEARINGS ON NATIONAL SCHOOL HEALTH SERVICES ACT OF 1947

On March 4, the Subcommittee on Health, of t Senate Committee on Labor and Public Welfa announced that it would hold hearings on S129 on Monday and Tuesday, March 8-9. The AM representative in Washington immediately co municated the announcement to Chicago, and h the promise of Dr. James R. Miller, of the Board Trustees, as a witness. He was given a place on t Tuesday program.

Origin—This bill, as originally drafted, was pra tically identical with HR1980, which Represent tive Howell introduced in the other House. O day of hearings was held on the House Bill la summer. Practically all those who testified favore the measure, but the Committee announced th before it would take action opportunity to be hear would be afforded to those who might oppose th bill. As previously announced, the lay sponsor o the bill is Mr. Hecht, of the *Parents Magazine*, an it has the hearty endorsement of the Parent-Teach ers Association.

Provisions—In brief, it provided that subsidie should be paid the States through the Children' Bureau of the FSA, to "establish and develop schoo health services for the prevention, diagnosis an treatment of physical and mental defects and con ditions of children." In some conferences held whil the bill was being drafted, the representatives of th AMA expressed agreement with the principle tha school children should have the best of medical care but disapproved of the school authorities providin treatment facilities.

Witnesses—The first witness was Oscar Ewing administrator of the FSA. He introduced extensiv amendments to the bill, quite materially changing its content. For instance, its scope is no longe limited to school children, but broadened to include "all youth of school age," and the program itself i modified to "develop in each state—especially in rural areas and areas suffering from severe economic distress—a comprehensive school health program for the health and physical well being of all children and youth of school age, pursuant to an integrated state plan which includes the supervision of health instruction and physical education programs, school

lth services, and school health examinations;" l health examination services is interpreted as aning "those activities of physicians, dentists, ses, teachers and other professional personnel." The amendment also removes the Children's eau as an authority and places the full adminis- tive function with the Administrator of the A. The personnel of the National Advisory Com- tee on Health Services; of twelve members, ich the original bill provided the President uld appoint; in the amendment are to be ap- nted by the Federal Security Administrator and include in their number three doctors of medi- e and "at least three members of the educational fession." The appropriation allotted is to be reased from ten to twelve million dollars, in ler to take care of the added physical education gram.

Dr. Martha Eliot, of the Children's Bureau, was second witness, and urged the endorsement of bill as amended. In her statement, she said, sing the most conservative estimates we have, example—we are faced with four million chil- n with visual defects, one million with hearing fects, 500,000 with orthopedic and plastic defects, ,000 with rheumatic fever and heart disease, and ,000 with epilepsy. She deplored the failure of ool health examinations, in 33 states, to provide Bureau with good data on the condition of ildren." Her idea is that the Bureau should be ected to develop demonstrations in each state the interest of uniformity.

Dr. Reginald Atwater, executive secretary of the nerican Public Health Association, was the third tness and also approved the original bill, but stated at he had not had sufficient opportunity of study- g the amendments.

On the second day the first witness was Dr. nes R. Miller of the AMA, who called the Com- ttee's attention to the fact that neither in the iginal bill nor the amended bill is there any pro- ion for consulting with the family of the child with the family physician. He supported the inciple of the bill that the best facilities for the evention and diagnosis of disabling conditions in ildren should be undertaken, on the State level, d not from a national level, and that correction d treatment must be a family responsibility. He esented statistics from his experience in com- nity work in Hartford, that showed that the milies will do their share. He called attention to the AMA's ten point program as proof of long standing interest in the subject. Senator Smith developed the idea of the State's responsibility, by cross-examination, and stated that he had had considerable correspondence with State officials to the point that they are greatly concerned over the inroads to their executive functions by national agencies. Dr. Miller also called attention to the fact that, when differences of opinion as to the merits of State programs arise between the Federal Security Administrator and the State authorities, the bill provided that the Administrator's opinion should be final—even though provision is made for public hearing. He suggested that the provision in the Hospital Construction Act—that such differences of opinion can be taken to the Circuit Court for a decision—be incorporated in this bill. Senator Smith commented on this matter by stating that he had asked Mr. Ewing, on the previous day, as to whether his authority in the administration of the Act was superior and final to that of the State.

Dr. Vlado Getting, the Health Commissioner of Massachusetts, suggested that the bill as amended (which he stated he had insufficient time to study carefully) contain two separate ideas: (1) medical examination and services for children; and (2) physical education and instruction; and further suggested that separate bills be drafted. Senator Saltonstall who was sitting with Senator Smith (no other members of the Committee were present at either hearing) stated that the introduction of the educational feature did not entirely meet with his approval, and that, at any rate, he wanted considerable time to study the amended bill before he should be able to decide upon its merits.

Dr. John P. Hubbard, of the Academy of Pediatrics, and director of the study which the Academy has been making of the health conditions of school children, testified in favor of the bill and presented some statistics which are the result of their study.

Clyde A. Erwin, superintendent of schools in North Carolina, and vice-president of the School Officers Association, stated that, in his Association's opinion, the bill offered the wrong approach to the problem, and that health services to school children is a problem of the Education Department and not of the Health Department. He even advised against a joint administration.

At the close of the hearings, Senator Smith announced that further hearings may be held. Obviously, the merits of the bill are quite controversial

and yet its backers, the PTA, do not seem particularly impressed by the defects and are likely to urge its enactment. Let us suggest, therefore, that each of you study the bill and discuss it with your Congressman.

Brookings Institution Study of Medical Care

In May 1947 Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Committee on Labor and Public Welfare, invited the Brookings Institution to study medical care for the individual in the United States and prepare a memorandum to help the Senate committee in its consideration of the bills on this subject. The study was completed and several conclusions reached. Of compulsory health insurance, the report of this private survey organization, which was sent to the senate labor committee, said:

1. Such a system would "necessitate a high degree of governmental regulation and control over personnel and the agencies engaged in providing medical care."

2. "It does not seem probable that politics could be eliminated from medical care supplied under a governmental system."

3. A "real danger" exists that government intervention would impair the relationship of practitioner and patient.

4. Administration "would require thousands of government employees for accounting, auditing, inspection and investigation."

5. "The cost of medical care presumably would increase."

The Institute made three recommendations which are published herewith:

1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Government administration. It seems highly improbable that this experimentation—possible under our Federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtle then be adopted with a great degree of unanimit If compulsory insurance should be adopted now b a narrow vote in the Congress, thousands of perso who are opposed to it would start hostile to th whole undertaking.

2. For the time being the National Governmer and many of the State governments may well devot their resources and energies to:

(a) Research and developments in the fields c public health;

(b) Health education at the school level;

(c) Teaching of preventive medicine;

(d) Assisting in the acquisition of physical facil ities and training of personnel;

(e) Providing systematic care for the indigent an the medically indigent. In some States careful sur veys of existing conditions will be required t furnish the basis for a comprehensive and coordi nated program.

3. From the standpoint of public relations, gov ernments might be well advised to leave adul educational campaigns for the control and preven tion of disease to the national, State, and loca voluntary organizations which have been able t enlist the active cooperation of leading laymen i most sections of the country. It must be remem bered that good health is not exclusively a matter o medical care; it also impinges upon causative fac tors that are non medical, such as food, shelter, vic and crime, transportation, and industry. Its main tenance depends also upon the intelligence, interest and cooperation of individuals, families, and loca communities.

These recommendations are not widely at vari ance with those of the majority of the Committe on the Costs of Medical Care, arrived at in 193 after a comprehensive study.

The years since 1932 have witnessed—

1. A great growth in voluntary insurance both for hospitalization and for medical services.

2. State experimentation with compulsory health insurance in Rhode Island and California.

3. A growing willingness on the part of practi tioners to cooperate in the development of prepay ment plans and other devices to enable patients who so desire to regularize their payments for medical care.

4. A profound change in the amount and distri bution of the earnings of the American people

his change greatly reduces the number who can-
ot afford adequate medical care if they desire to
urchase it.

The experience of the United States since 1932
ems to have demonstrated the wisdom of these
commendations of the majority of the members
the Committee on the Costs of Medical Care. It
ould seem unwise at this time to substitute for
ese developments a system of compulsory health
surance by national law which would have the
nfortunate tendency to freeze policies and eventu-
ly retard medical progress.

Pediatricians Playing With Fire

The American Academy of Pediatrics has pro-
osed that Congress appropriate $5,000,000 to pro-
de for grants-in-aid by the Federal Security
gency in support of pediatric education. This pro-
osal was made to the Health Subcommittee on the
asis that it is more important to train pediatricians
an to inaugurate a nationwide school health
rogram.

This is the way the Academy of Pediatrics pro-
osed that the $5,000,000 be spent:

(1) $2,500,000 to be allocated to medical schools
pproved by the AMA, such sums to be used as the
veral heads of departments of pediatrics think
est.

Each of the approved medical schools having
sidencies in pediatrics—there are 170 of these—
ould receive a minimum of $20,000.

The remainder of the $2,500,000 would be divided
nong the schools on the basis of needs and student
nrollments.

(2) $1,500,000 allocated for the following pur-
oses: (a) scholarships or fellowships; (b) expenses
f pediatric instructors making teaching circuits;
c) support for maintaining high standards of pedi-
ric education; (d) other purposes directly related
) pediatric education.

(3) Remaining $1,000,000 to be used for grants-
n-aid for graduate fellowships. These would be
ranted conditionally with the understanding that
cipients would return to areas in need of pedia-
icians in the States receiving the grants.

The proposal of the Academy of Pediatrics opens
ne door wide for Federal invasion of the sphere of
edical education. Once scholarships are granted
) medical schools, the Federal government would
move in and direct the distribution of these scholarships. It is the identical problem that faces the entire field of education today where large endowment funds have dwindled and the Federal government through tax laws has tapped the sources till they have dropped to a low water mark. It may be more important to train pediatricians than to inaugurate a nationwide health program such as proposed in S1290, but why must we have this training done through the largesse of Uncle Sam?

Social Security Administration Kitty

Weekly Underwriter for December 27, 1947 presents an analysis of the income and expenditures under the Social Security Act since its enactment in 1936. During these 11 years a total of $10,200,-800,000 has been contributed by the taxpayers of the United States. Only $1,689,600,000 have been paid out in benefits and the cost of administration has been $246,400,000. With the accumulated interest this leaves a social security kitty of $9,113,800,-000. For what purpose?

ACS Approves Use of Nurse Anesthetists

The Board of Regents of the American College of Surgeons, at a meeting on February 22, adopted a resolution commending the services of nurses who have had special training in the administration of anesthesia and recommending the continuance of training courses in this field for nurses. The resolution reads as follows:

The American College of Surgeons regards with deep concern the actions of some physician anesthesiologists in giving the impression to the laity in the public press that it is unsafe for experienced nurse anesthetists to conduct surgical anesthesia. While it supports the increasing tendency of having physician anesthesiologists in charge of surgical anesthesia, it deplores at this time any propaganda for the elimination of the trained nurse anesthetist. On the contrary, the American College of Surgeons is of the opinion that, in view of the inadequacy in number of the physician anesthesiologists and in view of the splendid record of achievement of the nurse anesthetists, institutions engaged in the training of nurses for this purpose should be encouraged to continue their programs.

COMMUNITY SERVICE CENTENNIAL

A five-year medical and social experiment featuring group medical practice as part of a community health plan was outlined by Bailey B. Burritt, executive director of the National Health Council, during a symposium held at the Hotel Roosevelt, New York City, on March 17 and 18 as part of the centennial program of the Community Service Society.

Mr. Burritt told the more than 600 guests attending the meeting that the new medical plan will be sponsored by "one of the great medical training schools" of the city, but did not name the institution.

Preceding Mr. Burritt's talk, the conference heard Dr. Innes H. Pearse, medical director of the Pioneer Health Centre of London, describe the "Peckham Experiment" in England, which is the model for the development of the New York plan.

As in the Peckham Experiment, Mr. Burritt pointed out, the keystone of the medical program will be based on the belief that the health of the individual is closely related to the health and habits of his family. The major objective of the plan will therefore be the maintenance of health in the family unit, he said.

"Such an experiment," he declared, "will enable us to learn more definitely what advances can be made in the prevention of illness and keeping families well. Through group medical practice, each member of the family will receive under the plan a thorough health appraisal periodically. Families will have available not only the various skills of physicians, but also those of the well trained social worker and public health nurse."

The health maintenance committee of the Community Service Society has already proposed that the society assist in financing the experiment over a period of years, Mr. Burritt said, but gave no indication when it will be inaugurated.

Dr. Pearse, reporting to the meeting the progress of the Peckham experiment, declared that the experiment has demonstrated that "health, like disease, is infectious." An interesting development at London's Pioneer Health Centre has been the narrowing of the gulf between activities of parents and their adolescent children, and the growth of health family living, she said.

Dr. Martha Eliot, associate chief of the Children Bureau, Federal Security Agency, and president o the American Public Health Association, addresse the morning session of the conference and warne that "unless the situation that exists is changed, on out of every 20 children alive today will sooner o later find himself a patient in a mental hospital."

Preventive measures for mental health must b developed as part of the regular child health services she remarked, and added: "The turn of the nex half century might then mean the beginning o action that will result in a generation of matur youth, well adjusted to live at peace with themselves, with their neighbors, and with all kinds o people all over the world."

In the principal address of the first morning session of the conference, Dr. C. E. A. Winslow, professor emeritus, Yale University, and editor of the *American Journal of Public Health*, emphasized that "what we must look forward to in the future is the replacement of arbitrary tribal codes by true education, the kind of education which aims at the molding of a free and responsible personality. Maturity, not crystallization of past mores, must be our objective."

"It is this new concept of maturity rather than conformity which must be cultivated in the homes of the future if our civilization is to survive."

He declared that, while social planning on a comprehensive scale is essential for survival in the modern complex and changing world, "we must firmly reject the two extreme philosophies, which so largely dominate the political thinking of the present day." These two philosophies he termed as being totalitarianism and anarchistic individualism.

"Neither unrestrained individual selfishness, nor blind submission to authority can solve the problems of the modern world. The only answer can be found, in the state as in the family, by the development of an attitude of maturity which combines recognition of the sacredness of the individual with recognition of common obligations to society."

STERILITY — NEW YORK CONFERENCE

The attractive ballroom of the Hotel Pierre, New ork City, was the scene on March 13 of the second nual conference of the American Society for the udy of Sterility. Urologists held the stage during e forenoon, to be succeeded by gynecologists in e afternoon session. David L. Belding reported me of the results of his experimental work in erility at Boston University School of Medicine. ere are some of them: The number of spermazoa and the viability drops with a rise in temperare over 65°F. There is no correlation between the te of conception and the sperm count. Although e comeback in sperm count following sexual cess varies in males from 3 to 5 days, the morphlogy is not affected. Abnormalities of sperm inease with stress and strain.

Myron G. Fincher, veterinarian at Cornell Uniersity, asserted that in animals at least where the perm is placed in the genital tract is not so importnt as the sperm itself. At least it should be placed the cervix. Undulent fever is a questionable cause f orchitis.

Hyaluronidase came in for considerable discusion. Raphael Kurzrok of Morrisania City Hospital, New York, was a strong proponent of its use in ncreasing fertilization. This enzyme is packed into he cervical canal with a platinum loop at the time f ovulation in cases of oligospermia with no yaluronidase present, also where the sperm count s over 150 million in the absence of hyaluronidase. Blood inhibits its action which lasts about 6 hours and the enzyme has been found by Kurzrok effective in 22 per cent of cases. Samuel L. Siegler from Woman's Hospital in New York had had no conceptions with the use of hyaluronidase. This enzyme is not available to all physicians as yet.

The testicular biopsy had its protagonists as well as antagonists. Fred Simmons of the Massachusetts General Hospital, Boston said it is not a harmful procedure and can be carried out in the office under local anesthesia. It should be done in the presence of aspermia on more than one occasion and with oligospermia after therapy. Biopsy from one testicle is a good mirror of both testicles. Harden it in Zenker's solution, not in formalin. Seymour Wilhelm of Beth Israel Hospital, New York, believes that a detailed examination of the seminal vesicle fluid often makes a testicular biopsy unnecessary.

Abraham Stone and I. C. Rubin squared off at each other a bit on the question of contraception affecting fertility. Dr. Rubin seemed to have the better of it until one realized that he saw only abnormal cases, so Dr. Stone's figures of 848 live births in 1,100 patients who had previously used contraceptives was hard to refute.

Charles Charny of Philadelphia advocated catheterization of the ejaculatory ducts. Most of the other urologists on the panel believed this procedure unnecessary, even harmful. Robert Hotchkiss of Bellevue Hospital advocated epididymal vasectomy. Then there was much discussion of abnormal sperm by Walter Williams of Springfield, Massachusetts, and of the various qualities of the sperm by John McLeod of Cornell. Penicillin has been found by Dr. McLeod to prevent growth of organisms that produce toxic substances affecting the sperm. He also was the authority for the statement that the fertilizing power of the sperm lasts longer than was formerly thought to be the case.

The gynecologists tangled on the subject of anovulatory bleeding. E. C. Hamblen of Duke University Medical School has found cyclic anovulatory bleeding present in less than 5 per cent of women. The more irregular a woman's cycle, the more reason is there for keeping a basal body temperature record and doing an endometrial biopsy. In Hamblen's hands gonadotropic therapy in cases of pituitary failure has yielded poor results. Weinstein of New York believes anovulatory sterility cannot be diagnosed without repeated endometrial biopsies. John Rock of Boston has proof that anovulatory women can ovulate at any time. Secretory endometrium does not always mean ovulation but merely that there is functioning progesterone. Rakoff of Philadelphia has found anovulation a common cause of sterility and the thyroid gland a more frequent cause of abortion than of sterility. He has used sheep or horse pituitary successfully in the first half of the cycle in cases of pituitary anovulation.

The precoital douche was supported by Charles Mazur and Fred Simmons. Tubal reconstruction was advocated by Edwin C. Robertson of Queen's University, Ontario, but is successful in only 2 to 5 per cent of cases. Rubin discussed tubal spasm, Fred Simmons the transportation of sperm through the Fallopian tube, and Weisman tubal insufflation following the gas with oil.

The full course luncheon in Pierre's Cotillion

Room was enhanced by the presence of the author of "Sexual Behavior in the Human Male," Professor Alfred C. Kinsey. Beyond carrying his audience back to the origin of sexual behavior in the baby, he stressed the importance of realizing that rapid ejaculation is characteristic of primates. The story of Professor Kinsey's research in male human behavior during the past years and the development of his "best seller" kept every one of the 275 present intensely interested. He told how he had held off the press all this time so that without any publicity on his part his book really sold. The percentage of error in the reviews of his book by scientists he found far greater than those done by the press. The reception by the public has forever removed the question of whether or not this material should be published. The opposition has come from a few groups of clinicians only. For every 6 letters he has received opposing the publication of his material there have been 1,000 in favor of it.

The American Society for the Study of Sterility is approaching 4 years of existence. It contains many enthusiastic gynecologists and endocrinologists and there is no lack of honest opinions expressed which are not at all times in agreement.

Peripateticus

Television at AMA in June

An elaborate television broadcast, demonstrating a varied program which will include medicine, surgery, gynecology, obstetrics, dermatology, neurology and urology, will be held during the annual American Medical Association session in Chicago, June 21-25.

Arrangements are being made by a committ composed of Drs. Walter Carroll, chairman, Stua Abel and Henry Wilson, all from Northweste University Medical School in Chicago. The thr are working with a group from the AMA.

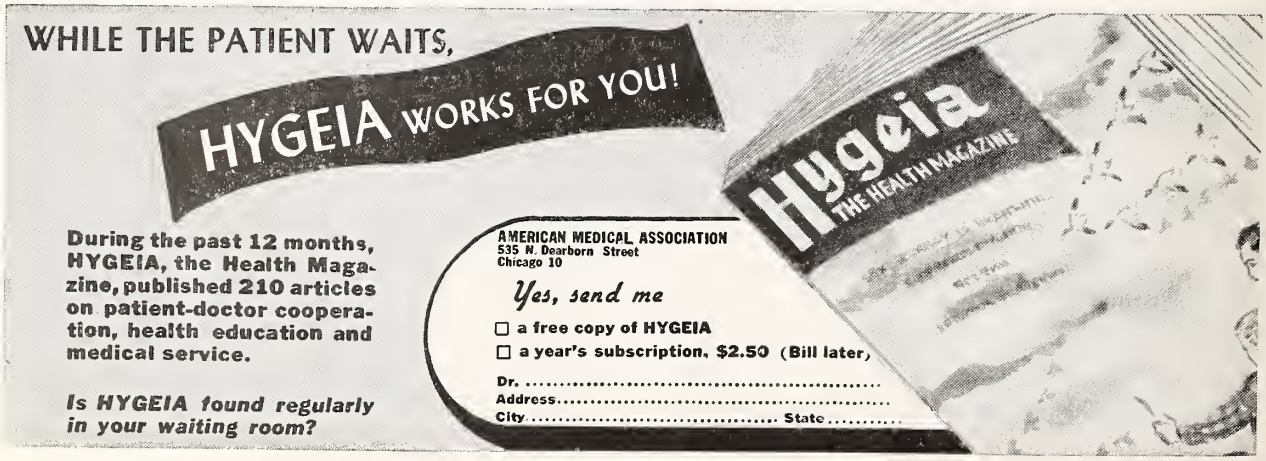
The programs will be beamed to an audience 450 at Navy Pier, where the AMA technical ar scientific exhibits will be held; to an audience 600 at the Hotel Sheraton on Chicago's Michiga Avenue, and to an audience of 600 who will occup classrooms at Northwestern University Medic School.

A Hospital Geriatric Department

Dr. L. Cosin, medical superintendent of a hos pital in Essex, England, in *The British Medical Jour nal** issues a plea for the organization of a geriatri department in the hospital. He reminds his reader that "three factors that will control geriatric car in the next few years are the persistent shortage o nursing staff, the variable conditions prevailing i municipal hospitals, and the lack of doctors an physiotherapists trained in geriatrics." He believe it will be possible to organize such departments s that nearly 50 per cent of aged patients can eithe be sent home or be given accommodation near th hospital and not require a full nursing service.

The medical profession is urged to change its attitude towards these patients with a view to providing them the best chance of enjoying ever limited activity and independence. The interest of the nursing staff must be reawakened and the important use of rehabilitation recognized.

*No. 4538, Dec. 27, 1947



"DOCTOR'S ORDERS"

THE CONNECTICUT STATE MEDICAL SOCIETY ON THE AIR

EVERY SUNDAY AT 1:15 P. M.

Yankee Network

		DIAL SETTINGS
WICC	Bridgeport	600
WWCO	Waterbury	1240
WONS	Hartford	1410
WNLC	New London	1490

Schedule

April 18	Spring Fever
April 25	Measles
May 2	Hair
May 9	Pre-Natal Care
May 16	Angina Pectoris
May 23	Care of Teeth
May 30	Appendectomy
June 6	Mental Hygiene
June 13	Strabismus
June 20	Nutrition — Summer Diet
June 27	Sunburn
July 4	Holiday Hazards
July 11	Heat Prostration
July 18	Swimming Safety

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Information About Medical Care of Veterans

The Committee on Medical Care of Veterans of the State Medical Society has asked that this information relative to the Home-Town Medical Care Plan be brought to the attention of the physicians of Connecticut. The successful operation of the Home-Town Medical Care Plan depends entirely upon the cooperative efforts of the physicians of the state and the Medical Division of the Veterans Administration. The State Society Committee on the Medical Care of Veterans has endeavored to publish information in the State Medical Journal and the Medical Division of the Veterans Administration has distributed information for the guidance of physicians in an effort to clarify the procedure and cut down red tape wherever possible. On the whole, the response of physicians in Connecticut have been commendable. There have, however, been a few instances when sufficient attention has not been given to instructions from the Veterans Administration. The result in these cases has led, not to decrease, but rather to an increase in paper work and in some instances circumstances have developed where the Veterans Administration, through no fault of its own, has been put in a position where it has beeen unable to pay for services rendered.

It is believed that the Home-Town Medical Care Plan can be a success through cooperation of all concerned and the result will be better medical care for Connecticut veterans and the reduction of paper work. The Medical Division of the Veterans Administration has recently mailed instructions to all participating physicians relative to a new and simple Authorization Form. The Society's Committee on Medical Care of Veterans has reviewed this new form and believes that it will simplify the work of physicians participating in the Veterans Medical Care Plan. It is urged that all physicians read these new instructions carefully to obviate future mistakes.

The Veterans Administration and the Committ on Medical Care of Veterans are deeply appreciati of the understanding and willing service that mer bers of the Society have given and look forwa to its continuance.

Creighton Barker, M.D.,
Executive Secretary

NP Residency at Newington

A Veterans Adminstration residency trainin program in neuropsychiatry, under supervision c the Dean's Committee, Yale University School c Medicine, will begin July 1 at the VA Hospital i Newington, Dr. Lewis G. Beardsley, manager, ar ounced recently.

The program will stress training in dynami psychiatry with emphasis on treatment and preven tion, and it will offer the required training in clini cal neurology. It is designed to prepare the residen for certification in psychiatry by the America Board of Neurology and Psychiatry.

The VA Hospital in Newington is a general hos pital of 352 beds with a psychiatric service of 4 beds.

The program will also be offered at the VA Hospital in Northampton, Mass., a 1,137 bed neuro psychiatric hospital.

Appointments will be made annually. Candidate may elect a one, two or three year course depending on their board requirements. Applications may b obtained from Dr. F. C. Redlich, chairman, Dean' Sub-Committee in Neuropsychiatry, Yale Univer sity School of Medicine, 333 Cedar Street, New Haven. All appointments are subject to approva by the Resident Review Board.

New Treatment Procedure

A simplified procedure for authorizing Connecti cut physicians to treat veterans on a fee basis will g into effect May 1, Harry T. Wood, manager of th

lartford Regional Office of the Veterans Admin-tration, announced recently.

Under the new procedure, a veteran or physician ill request the Chief Medical Officer at 95 Pearl treet, Hartford, for authority for treatment. If ie treatment is authorized, the VA will forward ie authority directly to the veteran concerned. The veteran may then take it to any fee basis physi-ian of his own choosing.

This is a departure from present procedure where uthority for treatment is mailed directly to the hysican.

The VA authority which the veteran will receive s on a simplified form and indicates the number of reatments authorized, the period covered by the uthorization and maximum fees allowed.

Veterans are warned, however, that the authori-ation is good only for the month specified. The uthorization is no longer valid after the specified eriod. It should, therefore, be presented to the hysician within the period allowed.

If additional treatments are needed during suc-eeding months, the treating physician will request ame from the Chief Medical Officer, Veterans Ad-ministration, Hartford.

Latest Report on Voluntary Prepaid Plans

The AMA reports that hospital and physicians' bills are now being paid for upwards of 50 million Americans by voluntary insurance plans. This report was made following a survey by the Council on Medical Service. The survey showed that 90 such plans are operating in the United States and that most make special provision for persons and families in the "low income group." This group varies according to living costs and other economic factors in the areas in which the plans operate.

The survey also showed more than half of the total working population of the country is protected against loss of income caused by accidents or illness. In excess of 40 million agreements are in effect, providing insurance against hospitalization costs. Upwards of 17 million persons have voluntarily provided themselves with insurance against costs of surgical care. Six million insurance agreements provide medical benefits other than hospital and surgical services, such as payment for home and office calls by physicians and similar services.

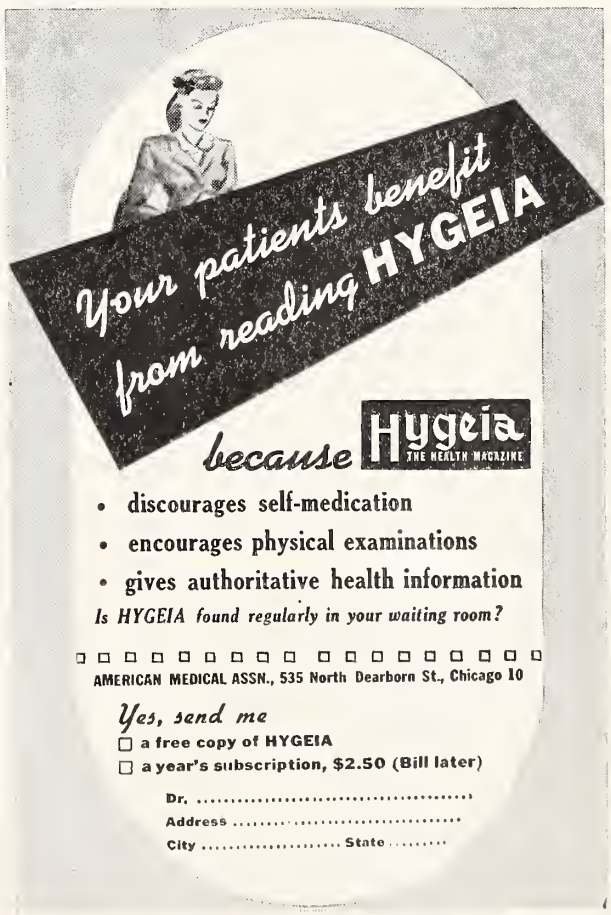
THE DOCTOR'S OFFICE

Harold S. Appell, M.D., announces the opening of an office for the practice of dermatology and syphilology at 79 Trumbull Street, New Haven.

Milton J. Cole, M.D., announces the opening of an office for the practice of internal medicine and cardiology at 75 Pratt Street, Hartford.

Ernest E. Englehart, M.D., announces the opening of an office for the practice of medicine and surgery at 21 Marshall Street, Hartford.

Donald R. Morrison, M.D., announces the opening of an office for the practice of general surgery at 1027 Farmington Avenue, West Hartford.



MILITARY BIOGRAPHIES (*Continued*)

These brief sketches of military experience of members of the Society have been compiled from data take from questionnaires completed by each medical officer. Biographical material for some officers is lackin because questionnaires were not returned.

CRANDALL, BRADFORD B., Mystic; b. 1908; Wisconsin 1934; Navy—August 16, 1940 Lt. (j.g.), Lt. June 15, 1942, Lt. Comdr. July 1, 1943, Comdr. November 1, 1945; Service Terminated December 16, 1946; Navy Yd., Philadelphia, Pa.; USS Decatur (North Atlantic); Elizabeth City, N. C.; Camp Peary, Va.; V-12, Appleton, Wis.; Lion Four, San Bruno, Calif.; Admiralty Island; C. B. 35, Admiralty Islands; USS Wasp (Asiatic-Pacific Theatre of Operation); USS Solace; Base Hospital 15, Great Lakes, Ill.; Sub. Base, New London, Conn.; Awards—Pre-Pearl Harbor; Unit Commendation (USS Wasp).

CRANE, JAMES E., Stamford; b. 1913; Vermont 1939; Army Air—February 10, 1941 Lt., Captain February 14, 1942, Major December 31, 1942; Service Terminated September 22, 1945; Duty—Ft. Benning, Ga.; Carlisle Barracks, Pa.; Camp Beauregard, La.; Camp Polk, La.; School of Aviation Medicine, Randolph Fld., Tex.; Air Surgeon's Office, Washington, D. C.; Combat Observor—Puerto Rico; South America; Africa; Iraq, India. Burma; China; Singapore; Java; Australia; New Zealand; New Caledonia; Hebrides; Guadalcanal; Fiji Islands; Canton; Palmyra; Hawaii; Bowman Fld., Ky.; Ft. Logan, Colo.; Awards—Bronze star w/oak leaf cluster; Letter of Commendation.

CRAWFORD, GEORGE B., Centerbrook.

CREADICK, ROBERT N., New Haven (Removed).

CRESSY, NORMAN L., New Haven; b. 1913; Yale 1939; Army—February 24, 1941; Lt., Captain April 27, 1942, Major January 30, 1944; Service Terminated April 8, 1946 (Lt. Colonel); Duty—43rd Division; Ft. McPherson, Ga.; Ft. Bragg, N. C.

CRISPELL, LAWRENCE S., Bridgeport; b. 1919; Yale 1944; Army—May 10, 1946 Lt., Captain May 9, 1947; (still on active duty) Battle Creek, Mich.; Duty—Dallas, Tex.; Camp Polk, La.; Ft. Sam Houston, Tex.; Percy Jones General Hospital; Washington, D. C.

CROSBY, EDWARD H., Hartford; b. 1901; Yale 1928; Navy—November 1941 Lt. Comdr., Comdr. September 1943; Service Terminated November 1945 (Captain); Duty—Brooklyn, N. Y.; Naval Hospital, Balboa, C. Z.; Base Fliver, Nicaragua; Philadelphia, Pa.; New River, N. C.

CULLEN, JAMES R., Hartford; b. 1906; Georgetown 1936; Navy—June 29, 1942 Lt., Lt. Comdr. October 17, 1944; Service Terminated March 8, 1946; Duty—Bethesda, Md.; Red Cross Blood Donor Service, Hartford, Conn.; Base Hospital #3, New Hebrides (Asiatic-Pacific Theatre of Operations); Norfolk, Va.

CUNNINGHAM, ROBERT D. M., Stamford; b. 1905; Yale 1930; Army air—September 11, 1942 Captain, Major March 6, 1946; Service Terminated May 19, 1946; Duty—Westover Field, Mass.; Key Field, Mississippi; Municipal Airport, Greenfield, South Carolina; 70th Service Company, Station Hospital, Warner Robins, Georgia; AAF Regional Hospital, Greensboro, North Carolina; Mitchell Field, New York.

CURLEY, WILILAM H., JR., Bridgeport; b. 1914; Cornell 1938; Navy—July 1, 1941 Lt. (j.g.) Lt. June 1942, Lt. Comdr. March 1, 1944; Service Terminated December 1, 1945; Duty—Sub. Base, New London, Conn.; Annapolis, Md.; USS Merrimack (North Atlantic); Philadelphia, Pa.; St. Albans, N. Y.; Hunter College, Bronx, N. Y.; USS Beaver (Aleutians); Navy Yd., Boston, Mass.; Awards—Pre-Pearl Harbor Ribbon.

CURNEN, EDWARD C., JR., New Haven; (Entered service from New York City); b. 1909; Harvard 1935; Navy—March 2, 1942 Lt. (j.g.), Lt. June 1942, Lt. Comdr. March 1944, Comdr. November 1945; Service Terminated September 8, 1946; Duty—Naval Research Unit, Rockefeller Institute for Medical search, New York, N. Y.

CURRAN, TIMOTHY L., Hartf (Entered service from Dorche Mass.); b. 1913; Boston University 1 Army Air—August 30, 1942 Lt., Cap August 2, 1943; Service Termin December 6, 1945; Duty—Ft. M Fla.; Arcadia, Fla.; Randolph Fld., T Tyndall Fld., Fla.; Atlantic City, N 12th and 15th Air Forces (Overse Awards—Unit Citation; 11 battle star

CURTIS, BURR H., Hartford; b. 19 Columbia 1936; P.H.S. (Navy)—A 5, 1943 Passed Assistant Surgeon, S geon July 7, 1944; Service Termina July 27, 1945; Duty—Sheepshead Hospital, Manhattan Beach, N. Y.

CUTLER, HERMANN S., New Hav b. 1910; St. Louis University 1937; P S. (U.S.C.G.)—Lt. (j.g.) April 17, 19 Lt. 1943; Service Terminated Febru 27, 1946; Duty—Washington, D. C., Augustine, Fla.; Baltimore, Md.; Sta Island, N. Y.

CZYZ, STANLEY I., Bristol; b. 19 Loyola 1943; Army—October 7, 19 Lt., Captain October 6, 1946; Serv Terminated October 19, 1946; Duty Continental United States and Europe African-Middle Eastern Theatres of O erations.

D'ALESSIO, CHARLES M., Derby; 1911; Maryland 1937; Army—June 1942 Lt., Captain January 21, 194 Service Terminated December 2, 194 Duty—Camp Forrest, Tenn.; Ne Guinea; Morotai, N.E.I.; Leyte, Luzo P. I.; Awards—Asiatic Pacific Ribb w/3 battle stars; Philippines Liberati Ribbon w/1 star; Bronze star; Purp Heart; Unit Meritorious Insignia; Co bat Medical Badge.

DALMAIN, WALTER A., Bristol.

DALY, JOSEPH L., JR., Norwich.

D'AMBRUOSO, DOMINIC C., Derb b. 1910; Columbia 1936; Army—Jun

1943 Lt., Captain January 1945; ce Terminated November 29, 1945; —Camp Davis, N. C.; Camp But- N. C.; 137th General Hospital, nd (European Theatre of Opera-).

IICO, MICHAEL, New Haven; b. Yale 1931; Army—July 15, 1942 t, Lt. Colonel November 3, 1943; ce Terminated February 18, 1945; —Camp Edwards, Mass.; Camp man, Calif.; 39th General Hospital ckland, N. Z.—Saipan, M. I. tic-Pacific Theatre of Operations.)

TRICH, ALBERT W., Litchfield; red service from Philadelphia, b. 1913; Yale 1939; Army Air— ry 21, 1943 Lt., Captain February 944; Major April 28, 1946; Service inated July 7, 1946; Duty—Miami a, Fla.; Randolph Fld., Tex.; Tyn- Fld., Fla.; Blytheville, Ark.; Fort dan, Ill.; Columbus, Miss.; School of ion Physiology; School of Allergy.

IS, DONALD A., Derby; b. 1911; emann 1936; Navy—June 26, 1944 Service Terminated June 9, 1946; —Sub. Base, New London, Conn.; ort, R. I.; USS Devosa (Asiatic- c Theatre of Operations); Bain- e Md.; Awards—Asiatic-Pacific tre Ribbon w/1 battle star; (Com- oned as a 1st Lt. U. S. Army ORC 11, 1936—expired June 11, 1941).

IS, JACHIN B., New Haven; b. Kansas 1933; Army—July 15, Captain; Service Terminated Janu- 1, 1946; 91st Evacuation Hospital— terranean Theatre of Operations— pean Theatre of Operations; 97th uation Hospital—Morocco, Algeria, sia, Sicily, England, France, Hol- Germany; Awards—5 battle stars.

IS, JAMES S., South Norwalk; b. Boston University 1939; Army— h 27, 1944 Captain, Major June 7, Service Terminated June 14, 1947; —Continental United States.

IS, JEFF, Stamford; (Entered serv- rom New York, N. Y.); b. 1906; nnati 1934; Army—February 21, Captain, Major February 1943; ce Terminated December 1945; —Army Medical Research Labora- Cushing General Hospital, Fram- m, Mass.; 6th Service Command ; Asiatic-Pacific Theatre of Opera- ; Letterman General Hospital, San cisco, Calif.

DAVOL, RECTOR T., Greenwich; b. 1915; Columbia 1941; Navy—September 6, 1943 Lt. (j.g.), Lt. January 1, 1945; Service Terminated February 1, 1946; Duty—School of Tropical Medicine; Naval Medical School, Bethesda, Md.; USS Franklin (Atlantic); USS Aegir (Pacific); Camp Lejeune, N. C.

DAY, HARRY L., New Haven; b. 1903; Yale 1934; Army Air—June 15, 1942 Captain, Major November 3, 1945; Service Terminated January 5, 1946; Duty—Flight Surgeon—Westover Fld, Mass.; Randolph Fld., Tex.; Nashville, Ten.; Richmond, Va.; Baltimore, Md.; Wright Fld., Ohio; Ft. Snelling, Minn.; 122nd General Hospital, England—83rd General Hospital, France (European Theatre of Operations).

DEAN, STANLEY R., Stamford; b. 1908; Michigan 1934; Army—December 12, 1943 Lt.; Service Terminated April 1945; Duty—Mason General Hospital, Brentwood, N. Y.; School of Military Neuropsychiatry.

DEKLYN, WARD B., Danbury; b. 1916; Temple 1941; Army—October 15, 1942 Lt., Captain February 1944, Major November 1945; Service Terminated April 14, 1946; Duty—Ft. Dix, N. J.

DEMING, ARCHIBALD S., Hartford.

DEPASQUALE, FRANCIS L., Hartford.

DEPASQUALE, JOHN A., Hartford; b. 1908; Pennsylvania 1936; Army—February 24, 1941 Captain, Major July 1942, Lt. Colonel September 1945; Service Terminated May 19, 1946; Duty—Camp Blanding, Fla.; Camp Shelby, Miss.; Fort Ord, Calif.; South Pacific; Camp Gordon Johnston, Fla.; Award—Army Commendation Ribbon.

DEREN, M. DAVID, Bridgeport; (Entered service from Syracuse, N. Y.); b. 1908; Syracuse 1933; Army—April 1942 Captain, Major 1943, Lt. Colonel 1945; Service Terminated August 31, 1946; Duty—Houlton, Me.; Presque Isle, Me.; Ft. Devens, Mass.; European Theatre of Operations; Ft. Douglas.

DERKACH, STEPHEN L., Greenwich; (Entered service from Philadelphia, Pa.); b. 1910; Hahnemann 1940; Navy—December 1942 Lt. (j.g.); Lt. March 1944; Lt. Comdr. January 1946; Service Terminated March 1946; Duty—Washington, D. C.; North Africa; Sicilian Invasion; England; Normandy Invasion; Camp Bradford, Va.; Melbourne, Fla.; Philadelphia, Pa.; Award—Bronze star.

DESMOND, CHARLES T., Hartford; b. 1908; Boston University 1938; Army—January 6, 1941 Lt., Captain December 24, 1941; Service Terminated December 26, 1945; Duty—Carlisle Barracks, Pa.; Camp Edwards, Mass.; Asiatic-Pacific Theatre of Operations; European Theatre of Operations.

D'ESOPO, JOSEPH N., New Haven; b. 1903; McGill 1931; Army—July 15, 1942 Captain, Major January 22, 1945; Service Terminated November 2, 1945; Duty—39th General Hospital, Auckland, N. Z.; Saipan, M. I.; Award—Citation for Meritorious Service.

DETORA, ALBERT M., Middletown; b. 1914; Boston University 1940; Army—August 10, 1942 Lt., Captain June 1, 1944; Service Terminated January 10, 1946; Duty—European Theatre of Operations—England, France, Germany, Belgium, Czechoslovakia; Award—Presidential Unit Citation.

DIAMOND, EDWARD H., Norwalk; b. 1906; Breslau (Germany) 1932; Army—October 21, 1942 Lt., Captain March 1, 1944; Service Terminated May 23, 1946; Duty—Ft. Morrow, Alaska; Ft. Richardson, Alaska (Asiatic-Pacific Theatre of Operations); Camp Upton, N. Y.

DIBLANDA, HARRY A., Westport; (Entered Service from New York City); b. 1905; New York Medical College 1932; Army—September 15, 1942 Lt., Captain February 22, 1944; Service Terminated June 2, 1946; Duty—Continental United States.

DICHTER, IRVING S., Stamford; b. 1906; Jefferson 1931; Army—October 22, 1943 Lt., Captain October 16, 1944; Service Terminated December 25, 1945; Duty—Camp Cooke, Calif.; California-Arizona Maneuver Area; Carlisle Barracks, Pa.; Ft. Jackson, S. C.; Gen. Surg. Team—105th Evacuation Hospital, Semi-Mobile—Rhineland-Central Europe (European Theatre of Operations); Awards—2 battle stars.

DIGIANDOMENICO, ALBERT T., Meriden; b. 1914; St. Louis University 1941; Army—July 1, 1942 Lt., Captain February 3, 1943; Service Terminated March 20, 1946; Duty—Carlisle Barracks, Pa.; School of Tropical Medicine; Camp

Shelby, Miss.; Camp Pickett, Va.; Southwest Pacific Area; Awards—Bronze star.

DINOLT, ROBERT, Putnam; (Entered service from Chicago, Ill.); b. 1906; Vienna (Austria) 1930; Army—June 3, 1944 Lt., Captain June 1, 1945, Major December 27, 1946; Service Terminated March 24, 1947; Duty—Carlisle Barracks, Pa.; Charleston, S. C.; Camp Shelby, Miss.; 120th Evacuation Hospital (European Theatre of Operations); Camp Polk, La.

DION, ASA J., Hartford; b. 1902; Tufts 1928; Army—October 22, 1943 Captain; Service Terminated September 29, 1945; Duty—Carlisle Barracks, Pa.; 6th Service Command Hdq., Chicago, Ill.; Gardiner General Hospital, Chicago, Ill.

DIONNE, ULRIC A., Waterbury.

DISKAN, ALBERT E., Manchester; b. 1912; Temple 1937; Army—February 24, 1941 Lt., Captain October 1, 1941, Major May 15, 1943, Lt. Colonel January 3, 1946; Service Terminated February 13, 1946; Duty—Carlisle Barracks, Pa.; Camp Blanding, Fla.; Christmas Island —204th General Hospital (Asiatic-Pacific Theatre of Operations).

DOBKINS, JOHN J., Stamford; (Entered service from New York City); b. 1913; Toronto 1939; Army—September 21, 1942 Lt., Captain June 1943; Service Termniated July 16, 1946; Duty—Carlisle Barracks, Pa.; Langley Fld., Va.; Edgewood Arsenal, Md.; New Caledonia; New Zealand; Saipan, M. I. (Asiatic-Pacific Theatre of Operations).

DODD, BURWELL, Hartford; b. 1906; Columbia 1933; Army—September 19, 1942 Captain, Major May 1945; Service Terminated March 2, 1946; Duty—Ft. Devens, Mass.; Waltham, Mass.

DOLCE, JAMES A., Hartford; (Entered service from Arlington, Va.); b. 1899; South Carolina 1925; P.H.S.—1940 Surgeon; Service Terminated August 1947; Fairfax, Prince William Stafford Counties, Va.; Wilmington, Del.; (Removed to New York).

DONADEO, JOHN J., Bridgeport; (Entered service from Pittsburgh, Pa.); b. 1915; Bologna (Italy) 1942; Army—April 8, 1944 Lt., Captain April 12, 1945; Service Terminated September 1, 1946; Duty—Carlisle Barracks, Pa.; Ft. Lewis, Wash.; European Theatre of Operations; Awards—Medical Combat Badge, Bronze star; European Theatre of Operations w/3 battle stars.

DONNELLY, WILLIAM A., Bridgeport; b. 1913; Cornell 1940; Army—May 15, 1942 Lt., Captain April 7, 1943; Service Terminated February 3, 1946 (Major); Duty—Ft. Bragg, N. C.; Transport Surgeon (Atlantic); Africa, Italy; Ft. Myer, Va.; Awards—Combat Medical Badge; Bronze star; Purple Heart; European Theatre Ribbon w/3 battle stars; American Theatre Ribbon w/1 battle star.

DORION, N. EDWARD, New Britain.

DORION, ROBINSON H., Stamford; b. 1907; Vermont 1932; Navy—April 9, 1942 Lt., Lt. Comdr. March 1944; Comdr. November 1945; Service Terminated February 2, 1946; Duty—USS Ranger (Atlantic); Sub. Base, New London, Conn.; Noroton, Conn.; Newport, R. I.; USS Osage (Pacific); Awards—3 Bronze stars.

DRESSLER, MORRIS, Hartford; b. 1902; Long Island College of Medicine 1927; Army—March 4, 1944 Captain, Major March 31, 1946; Service Terminated May 23, 1946; Duty—Veterans Hospital, Newington, Conn.

DUBOIS, ROBERT E., Waterbury; b. 1909; Maryland 1935; Navy—November 29, 1943 Lt., Lt. Comdr. December 1, 1945; Service Terminated April 23, 1946; Duty—Newport, R. I.; Quantico, Va.; Navy Pier, Chicago; Leyte, P. I.; Okinawa; Samar, P. I. (Asiatic-Pacific Theatre of Operations).

DUCKER, STUART R., Newtown (Entered service from Ft. Myers, Fla.); b. 1920; Duke 1944; Navy—July 1, 1943 A/S V-12, Lt. (j.g.) September 23, 1944; Service Terminated June 29, 1946; Duty —Pensacola, Fla.; ARL 32; USS Oneida; Miami Beach, Fla.

DUFFY, LEO T., Hartford; b. 1908; Tufts 1934; Army—February 14, 1941 Major, Lt. Colonel November 3, 1945; Service Terminated November 17, 1945; Duty—Camp Blanding, Fla.; Camp Shelby, Miss.; South Pacific; Stark General Hospital, Charleston, S. C.; Ft. Devens, Mass.; Awards—Asiatic-Pacific Theatre Service Medal w/3 battle stars; Philippine Liberation Medal w/1 battle star.

DUNN, MORRIS L., New Britain; b. 1916; New York University 1943; Army —July 1945 Lt., Captain November 1946; Service Terminated January 13, 1947—Duty—Carlisle Barracks, Pa.; gional Hospital, Camp Lee, Va.; Me Detachment and Hospital, Fort K Canal Zone.

DURKEE, RALPH E., Hartford; b. 1 Harvard 1936; P.H.S.—May 3, Passed Asst. Surgeon, Surgeon; Se Terminated May 23, 1946; Duty—P Health Service Hospital, Sheeps Bay, N. Y.

DUSHANE, JOSEPH E., Hartford tered service from Haverhill, Mass 1909; Tufts 1936; Army—Septembe 1940 Lt., Captain December 21, 1 Service Terminated January 12, (Major); Duty—Losey Fld., Pu Rico; Great Falls, Montana.

DUZMATI, PAUL P., Bridgeport 1909; Jefferson 1936; Army—January 1943 Lt., Captain November 11, 1 Servcie Terminated April 26, 1 Duty—Carlisle Barracks, Pa.; Engl France, Belgium, Holland, Germ (European Theatre of Operatio Awards—Purple Heart; Unit Citat 5 campaign stars.

DWYER, CHRISTOPHER E., Wa bury.

EBERS, THEODORE M., Hartford tered service from Los Angeles, Cali b. 1906; Nebraska 1931; Navy—Au 17, 1942 Lt., Lt. Comdr. July 1945; S ice Terminated February 1, 1946; Dut Bureau of Medicine and Surgery, W ington, D. C.; Marine Barracks, Qua co, Va.; School of Neuropsychiatry, U Hospital, Philadelphia, Pa.; U. S. Na Hospitals, Brooklyn, N. Y.; Great La Ill.; Mare Island, Calif.

ECKERT, GEORGE R., Danbury; 1909; Tufts 1933; Army—October 1942 Lt., Captain February 11, 19 Service Terminated October 22, 19 Duty—Miami Beach, Fla.; Pyote, T School of Aviation Medicine, Rando Fld., Tex.; Ephrata, Washington; Ra City, S. D., McDill Fld., Tampa, F Lakeland, Fla.; Flight Surgeon—15th Forces (Mediterranean Theatre of O ations); Awards—Presidential Unit C tion w/oak leaf cluster; European Th tre of Operations w/8 bronze battle st

EDDY, MAXON H., Bridgeport; 1907; Harvard 1935; Navy—May 3, 1 Lt., Lt. Comdr.; Service Termina April 23, 1946; Duty—Chelsea, Ma South Pacific; Ft. Eustis, Va.; Brookl N. Y.

ESON, DEAN H., Danbury; b. 1916; Vermont 1942; Army—July 1, 1943 Lt., Captain April 1, 1944; Service Terminated April 13, 1946 (Major); Duty—Carlisle Barracks, Pa.; School of Neuropsychiatry, England; Camp Hood, Tex.; France and Belgium (European Theatre of Operations).

EAN, JOHN J., Newington.

EGOSIN, RICHARD B., Hamden (Entered service from Whitefield, N. H.); b. 1915; McGill 1940; Army—June 23, 1943 Lt., Captain June 25, 1944; Service Terminated August 24, 1946 (Major); Duty—Camp Davis, N. C.; Guadalcanal; Philippines; Japan (Asiatic-Pacific Theater of Operations).

ELRICH, DAVID L., Westport; b. 1910; Jefferson 1928; Army Air—September 29, 1942 Captain; Service Terminated September 12, 1943; Duty—Alliance, Nebr.; Miami Beach, Fla.; University of Tennessee-Memphis, University of Michigan—Ann Arbor—X-ray and Clinical Laboratory.

ESBERG, CHARLES P., New Britain (Entered service from Port Chester, N. Y.); b. 1909; New York Medical College 1933; Army—August 1942 Lt., Captain November 1943; Service Terminated September 1944; Duty—Middle Eastern and Italian Theatres of Operation.

EGLISH, HARRISON F., Waterbury (Entered service from Trenton, N. J.); b. 1912; Jefferson 1938; Army—April 1, 1941 Lt., Captain January 22, 1942; Major July 17, 1942; Service Terminated December 29, 1945; Duty—Carlisle Barracks, Pa.; Fort Dix, N. J.; Fort H. G. Wright, N. Y.; Ft. Devens, Mass.; Third Army—England, France, Germany, 12th and 101st Evacuation Hospitals (European Theatre of Operations); Awards—European Theatre of Operations Ribbon w/5 battle stars; (Removed to New Jersey).

STEIN, BENJAMIN, Danbury (Entered service from Bedford, Mass.); b. 1910; Vienna (Austria) 1936; Army—March 4, 1944 Captain; Service Terminated October 12, 1946 (Major); Duty—Veterans Administration—Bedford, Mass. and Wadsworth, Kan.

STEIN, CHARLES J., New Haven.

STEIN, JOSEPH I., Portland.

KWITH, IRWIN S., Bridgeport; b. 1915; Syracuse 1940; Army—April 11, 1942 Lt., Captain January 1943; Service Terminated May 1945; Duty—Army X-ray School, Washington, D. C.; Fort Ethan Allen, Vt.; Ft. Devens, Mass.; New Guinea (Asiatic-Pacific Theatre of Operations).

ESPOSITO, JOSEPH J., Bridgeport; b. 1912; Columbia 1937; Navy—February 19, 1945 Lt.; Service Terminated July 23, 1946; Duty—St. Albans, N. Y.; Pearl Harbor, T. H.; Aiea Hts., T. H.

EWELL, JOHN W., New Haven.

FABRO, J. ALFRED, Torrington (Entered service from Fall River, Mass.); b. 1911; Tufts 1937; Army—June 1, 1943 Lt., Captain June 1944; Service Terminated June 1946; Duty—7th General Hospital, England; 317th Station Hospital, Weisbaden, Germany (European Theatre of Operations).

FAGAN, FRANCIS X., Hartford; b. 1901; Cornell 1933; Army—August 21, 1942 Major; Service Terminated January 19, 1946 (Lt. Colonel); Duty—Camp Devens, Mass.; Camp Campbell, Ky.; Camp Gordon Johnston, Fla.; Camp Gordon, Ga.

FAGAN, FREDERICK J., New London.

FARMER, JOSEPH A., Hartford.

FEENEY, THOMAS M., Hartford; b. 1910; Boston University 1936; Navy—September 13, 1943 Lt., Lt. Comdr. October 1945; Comdr. March 1946; Service Terminated October 5, 1946; Duty—European, Mediterranean, South West and Central Pacific Theatres of Operation—Invasions Normandy, Southern France, Iwo Jima, and Okinawa; Awards—5 battle stars.

FEENEY, PHILIP W., New Haven; b. 1907; Tufts 1931; Navy—September 7, 1942 Lt., Lt. Comdr. June 1945; Service Terminated March 6, 1946; Duty—Newport, R. I.; Norfolk, Va.; Third Special USN C.B., Espiritu Santo, New Hebrides (Asiatic-Pacific Theatre of Operations); Davisville, R. I.

FEYDER, SIDNEY, New Haven; b. 1911; Rochester 1936; Army—July 15, 1942 Captain, Major May 22, 1945; Service Terminated December 11, 1945; Duty—39th General Hospital, Camp Edwards, Mass.—Auckland, N. Z. (Asiatic-Pacfic Theatre of Operations); Awards—Asiatic-Pacific Theatre Ribbon w/1 battle star; (Removed to Rochester, N. Y.).

FINDORAK, FRANCIS G., Bridgeport; b. 1906; Georgetown 1932; Army—February 24, 1941 Lt., Captain August 5, 1942; Service Terminated February 26, 1946 (Major); Duty—Carlisle Barracks, Pa.; Camp Blanding, Fla.; Camp Shelby, Miss.; Camp Claiborn, La.; Normandy, Northern France; Ardennes, Rhineland, Central Germany (European Theatre of Operations); Awards—Pre-Pearl Harbor; European Theatre Ribbon w/5 battle stars.

FINE, JOSEPH, Stamford; b. 1906; Pennsylvania 1931; Army—November 5, 1943 Lt., Captain September 25, 1945; Service Terminated June 29, 1946; Duty—Carlisle Barracks, Pa.; Ft. Sam Houston, Tex.; Camp Gruber, Okla.; Camp Shelby, Miss.; Ft. Benning, Ga.; Lawson General Hospital, Atlanta, Ga.; Camp Wheeler, Ga.; Ft. Bragg, N. C.; Ft. Dix, N. J.

FIORITO, JOSEPH A., New Haven; b. 1910; Washington University 1937; Army—August 15, 1941 Lt.; Service Terminated October 4, 1941; Duty—Walter Reed General Hospital, Washington, D. C.

FIRESTONE, SIEGFRIED D., Rockville (Entered service from North Tonawanda, N. Y.); b. 1911; Lausanne (Switzerland) 1934; Army—August 12, 1942 Lt Captain February 1944; Service Terminated February 14, 1946; Duty—Carlisle Barracks, Pa.; Desert Training Center; European Theatre of Operations; Awards—Belgian Fourragere; European Theatre ribbon w/5 battle stars; (Removed to North Carolina).

FISCHER, WILLIAM J. H., JR., Milford (Entered service from Providence, R. I.); b. 1914; Columbia 1941; Army—July 13, 1942 Lt., Captain October 23, 1943; Service Terminated February 14, 1946; Duty—Ft. Banks, Mass., Tennesse Maneuvers—48th Evacuation Hospital (China-India-Burma Theatre of Operations); Awards—Asiatic-Pacific Theatre Ribbon w/2 battle stars; Meritorious Service Plaque; (Removed to R. I.).

FLANAGAN, EDWIN D., South Norwalk.

FLYNN, HAROLD A., New Haven; b. 1902; Yale 1927; Army—September 24, 1943 Captain, Major January 27, 1946; Service Terminated March 28, 1946; Duty—Carlisle Barracks, Pa.; Camp McCoy, Wisc.; 132nd General Hospital—

New Guinea—Biak (Asiatic-Pacific Theatre of Operations).

FLYNN, HERBERT L., Mansfield Depot (Entered service from Belchertown, Mass.); b. 1901; Vermont 1929; Army—April 1, 1941 Captain, Major June 24, 1942, Lt. Colonel April 11, 1943; Service Terminated January 16, 1946; Duty—Camp Edwards, Mass.; South Pacific; Ft. Lewis, Wash.

FORTIER, NORMAN L., Hartford.

FOSTER, HOLLIS JOSEPH, JR., Berlin; b. 1916; Hahnemann 1943; Army—November 1944 Lt., Captain August 6, 1945; Service Terminated November 13, 1946; Duty—European Theatre of Operations; Awards—Combat Medical Badge; European Theatre Ribbon w/2 battle stars; Unit Citation.

FOX, JAMES C., JR., Hartford; b. 1895; Johns Hopkins 1920; Army—May 18, 1942 Lt. Colonel; Service Terminated November 22, 1945 (Colonel); Duty—Lovell General Hospital, Ft. Devens, Mass.; Unit Director, 39th General Hospital, Auckland, N. Z. (Asiatic-Pacific Theatre of Operations); Cushing General Hospital, Framingham, Mass.; Award—Bronze star.

FRANCO, JOHN E., Hartford.

FRIEDBERG, ISADORE H., Newington; b. 1912; Tufts 1937; Army—February 24, 1941 Lt., Captain June 21, 1942; Service Terminated February 26, 1946; Duty—169th Infantry; 102nd Infantry; Tripler General Hospital, Asiatic-Pacific Theatre of Operations.

FRIEDMAN, EMERICK, Norwich; b. 1910; Buffalo 1934; Army Air—September 26, 1942 Captain; Service Terminated October 29, 1945 (Major); Duty—Jackson, Miss.; Arcadia, Fla.; Nashville, Tenn.; Plattsburgh, N. Y.; School of Aviation Medicine; (Removed to New York).

FRIEDMAN, IRVING, New Haven; b. 1907; Yale 1933; Army—July 1, 1942 Captain, Major February 11, 1944, Lt. Colonel May 6, 1946; Service Terminated August 5, 1946; Duty—Portland, Me.; Waltham, Mass.; 249th and 4th General Hospitals, Luzon, P. I. (Asiatic-Pacific Theatre of Operation).

FRIEDMAN, NATHAN H., Stratford; b. 1908; Tufts 1933; Navy—April 20, 1942 Lt. (j.g.), Lt., Lt., Comdr.; Service Terminated January 24, 1946; Duty—Newport, R. I.; USS Bancroft (Caribbean and Aleutians); School of Aviation Medicine Pensacola, Fla.; Memphis, Tenn.; USS Makin Island—Invasions of Leyte, Luzon, Iwo Jima and Okinawa (Asiatic-Pacific Theatre of Operations); San Diego, Calif.; Award—Bronze star.

FRIEDMAN, SAMUEL, Newtown.

FROTHINGHAM, JOHN G., New Canaan; b. 1907; Harvard 1935; Army Air—June 9, 1942 Lt., Captain July 1943; Service Terminated March 1946; Duty—Bradley Fld., Conn.; Mitchell Fld., N. Y.

FULDNER, RUSSELL V., New Haven; b. 1908; Columbia 1933; Army—July 15, 1942 Captain; Major March 1944; Service Terminated April 1, 1946 (Lt. Colonel); Duty—39th General Hospital. Auckland, N. Z., 18th General Hospital—South Pacific and China-Burma-India Theatres of Operation; Cushing General Hospital, Framingham, Mass.; Awards—Asiatic-Pacific Ribbon w/2 battle stars.

FULLER, ROGER H., Simsbury.

FUNKHOUSER, SELMES PAUL, Winsted; b. 1892; Washington University 1919; Army—February 10, 1944 Lt. Colonel; Service Terminated May 7, 1945; Duty—Veterans Administration, Bath, N. Y.

FURNISS, WILLIAM E., Bristol.

GAFFNEY, JOHN J., Danbury.

GAINES, NEMO D., Hartford.

GALEN, JACK H., Ansonia (Entered service from Brooklyn, N. Y.); b. 1917; Long Island College of Medicine 1942; Army Air—September 10, 1943 Lt., Captain March 1945; Service Terminated April 1946; Carlisle Barracks, Pa.; Wendover, Utah; Tinian (Atom Bomb Group)—(Asiatic-Pacific Theatre of Operations).

GALLO, FRANCIS, Winsted.

GARCIN, CECIL R., Danielson; b. 1900; McGill 1926; Navy—March 26, 1943 Lt. Comdr., Commander November 1, 1945; Service Terminated April 9, 1946; Duty—Camp Peary, Va.; Naval Hospital #128, Pearl Harbor, T. H.; Palmyra; (Asiatic-Pacific Theatre of Operations); Chelsea, Mass.

GARDNER, HORACE T., New Haven; b. 1913; Yale 1941—Army—July 1, 1942 Lt., Captain March 15, 1943; Ser Terminated April 19, 1946; Duty— lisle Barracks, Pa.; Caguas, P. R.; Juan, P. R.; 5307th Comp. Infa (Merrills Marauders) India and Bu Camp Joseph T. Robinson, Ark.; US Frances Y. Slanger; Awards—Dis guished Unit Badge; (Removed to York, N. Y.).

GARDY, LAWRENCE A., Hart (Entered service from New York Ci b. 1911; Bologna (Italy) 1937; Arm March 20, 1944 Lt., Captain Marc 1945; Service Terminated December 1945; Duty—Carlisle Barracks, Granite City, Ill.; Camp Van Dorn, M European Theatre of Operations; Aw —European Theatre Ribbon w/2 ba stars.

GAROFALO, MARIO L., New Ha b. 1907; Naples (Italy) 1935; Arm May 20, 1943 Lt., Captain May 19 Service Terminated February 25, 19 Duty—Ft. Devens, Mass.; Topkea, K Denver, Colo.

GEER, WILLIAM A., Bridgeport; 1907; Yale 1934; Army—November 1942 Captain, Major December 17, 19 Service Terminated November 9, 1 (Lt. Colonel); Duty—81st Station H pital; 300th General Hospital (Medi ranean Theatre of Operations); 9 Evacuation Hospital.

GEETTER, ISIDORE S., Hartford; 1902; Jefferson 1929; Navy—Decem 27, 1943 Lt. Comdr., Comdr. Novem 8, 1945; Service Terminated May 1946; Duty—Sub. Base, New Lond Conn.; Naval Hospital, Oakland, Cal Fleet Hospital #114—San Francis Calif., and Samar, P. I.; 126th Gene Hospital, Leyte, P. I. (Asiatic-Pac Theatre of Operations); Naval Hospit Philadelphia, Pa.

GENDEL, BENJAMIN R., New Hav b. 1911; Tulane 1935; Army—Octo 6, 1942 Lt., Captain June 1943; Ma November 1945; Service Termina August 26, 1946; Duty—Ft. Bragg, C.; Carlisle Barracks, Pa.; Europe Theatre of Operations; Ft. Devens, Ma

GENS, JOHN P., Darien; b. 1911; Y 1937; Army Air—September 22, 19 Lt., Captain June 7, 1944; Service T minated April 23, 1946; Duty—Carli Barracks, Pa.; Keesler Fld., Miss.; Ha mer Fld., Calif.

NTILE, ANGELO L., New Haven; b. 9; Boston University 1929; Army—ber 8, 1943 Captain; Service Termi- d October 18, 1945; Duty—Carlisle acks, Pa.; England and France ropean Theatre of Operations); rds—Certificate of Merit; 3 battle s.

NVERT, HAROLD; Norwalk (En- d service from New York City); b. 7; Yale 1936; Army—February 26, 3 Captain, Major December 1943, Lt. onel May 1945; Service Terminated 1946; Duty—Walter Reed General pital, Washingotn, D. C.; New Or- s, La.; Camp Campbell, Ky.; Eng- l-France-Germany-Austria (European atre of Operations).

RMAN, WILLIAM J., New Haven; 899; Harvard 1926; Navy—February 1944 Lt. Comdr., Comdr. October 4; Service Terminated May 17, 1946; y—St. Albans, N. Y.; Philadelphia, U. S. Naval Hospital, Aiea Heights, H.

ROW, GEORGE H., Westport; b. 2; Toronto 1925; Navy—December 1942 Lt. Comdr., Comdr. July 10, 5; Service Terminated May 21, 1946; y—Newprot, R. I.; 3rd Fleet—Fleet pital #5, Fleet Hospital #6, Fleet pital #8 (Pacific); 7th Fleet, Philip- es; L.S.T. #464 (Asiatic-Pacific Thea- of Operations); San Leandro, Calif.

VALT, FREDERICK C., JR., Lake- e (Entered service from West Rox- y, Mass.); b. 1914; Columbia 1940; vy—February 22, 1943 Lt. (j.g.), Lt. il 1, 1944, Lt. Comdr. June 1, 1946; vice Terminated June 15, 1946; Duty helsea, Mass.; 2nd Beach Bn.-North ica-Sicily-England-France (North Af- n-Mediterranean-European Theatre Operations); Awards—Purple Heart; nze star.

BSON, DONALD F., Danbury; b. 1; Yale 1927; Navy—July 29, 1942 Comdr., Comdr. 1945; Service Ter- nated January 21, 1946; Duty—Sub. e, New London, Conn.; Chemical rfare School, Md.; USS Hamul A.D. Chelsea, Mass.; Fleet Marine Force.

DDINGS, JAMES C., Meriden; b. 6; Vermont 1943; Army—December 1943 Lt., Captain December 16, 1944; vice Terminated August 11, 1946 ajor); Duty—Carlisle Barracks, Pa.; Devens, Mass.; Camp Pickett, Va.; European Theatre of Operations; Awards —Soldiers Medal; European Theatre Ribbon w/3 battle stars.

GIFFIN, LEWIS A., Hartford (Entered service from Alton, Ill.); b. 1910; Harvard 1935; Army—September 10, 1942 Captain, Major June 1, 1944; Lt. Colonel December 17, 1945; Service Terminated December 28, 1945; Duty—Denver, Colo.; European Theatre of Operations; Awards—European Theatre Ribbon w/5 battle stars.

GILLESPIE, HARRY, Hartford.

GILMER, ROY J., New Haven (Entered service from New York City); b. 1915; Meharry 1942; Army Air—December 26, 1943, Lt., Captain September 1945; Service Terminated April 1946; Duty—Tuskegee, Ala.; 484th AAA AW Bn. China-Burma-India Theatre of Operations; Awards—2 battle stars.

GISSLER, NORMAN E., Middletown; b. 1903; Yale 1928; Navy—February 1943 Lt. Comdr.; Service Terminated February 28, 1945; Duty—Sub. Base, New London, Conn.; USS Appalachian, (AGC 1) Amphibious Force Flagship; Farragut, Idaho; Awards—Letter of Commendation, CG 4th Marine Division.

GIUFFRIDA, FRANCIS, Meriden; b. 1910; Tufts 1937; Navy—July 1941 Lt. (j.g.), Lt. June 1942, Lt. Comdr. April 1944, Commander November 1945; Service Terminated March 1946; Duty—Portsmouth, N. H.; USS Ludlow (North Atlantic); Chelsea, Mass.; Newport, R. I.; USMC, Asiatic-Pacific Theatre of Operations; Awards—Bronze star; Presidential Unit Citation.

GLASER, WILLIAM, New Haven (Entered service from Brookline, Mass.); b. 1913; Tufts 1938; Army—September 25, 1942 Lt., Captain July 1943; Service Terminated June 4, 1946 (Major); Duty—Continental United States; Hawaii; Okinawa; Korea (Aisatic-Pacific Theatre of Operations).

GLASS, WILLIAM H., Hartford; b. 1912; Duke 1937; P.H.S. (U.S.C.G.)—April 6, 1942 Asst. Surgeon (R); Service Terminated October 1, 1943; Duty—U. S. Coast Guard Academy, New London, Conn.; Manhattan Beach, Brooklyn, N. Y.

GLIKE, FREDERICK P., Meriden; b. 1916; Yale 1941; Army—July 1, 1942; Lt., Captain May 1, 1943; Service Terminated January 16, 1946; Duty—Carlisle Barracks, Pa.; Camp Butner, N. C.; Camp Forrest, Tenn.; 3rd Army—Northern Ireland, England, France, Luxembourg, Belgium, Germany (European Theatre of Operations); Award—Bronze star.

GLORIG, ARAM, JR., New Haven (Entered service from Atlanta, Ga.) b. 1906; Medical Evangelists 1937; Army—May 2, 1942; Lt., Captain January 1, 1944, Major December 27, 1945; Service Terminated March 20, 1946; Duty—Atlanta, Ga.; Iceland; 7th General Hospital; England; 101st General Hospital, Berlin, Germany; (Removed to Washington, D. C.).

GODFREY, ELLWOOD W., Hartford (Entered service from Philadelphia, Pa.); b. 1910; Pennsylvania 1937; Navy —February 15, 1942 Lt. (j.g.), Lt., Lt. Comdr., Comdr.; Service Terminated June 20, 1946; Duty—Asiatic-Pacific Theatre of Operations; Continental United States.

GOETSCH, JOHN B., New Haven.

GOLDSCMIDT, MYER, New Britain; b. 1910; Virginia 1938; Army—August 19, 1942 Lt., Captain April 1943; Service Terminated December 31, 1945; Duty—School of Tropical Diseases; England-France-Luxembourg, Germany (European Theatre of Operations); Awards—Bronze star; 5 battle stars.

GOLDYS, FRANK M., Danbury; b. 1901; Tufts 1926; Army Air—October 12, 1943 Captain; Service Terminated December 21, 1945 (Major); Duty—Warner Robins Fld., Ga.; Venice Fld., Calif.; Andrews Fld, Washington, D. C.

GOLINO, EMANUEL F., Hartford; b. 1910; Rochester 1936; P.H.S. (USCG)—June 1, 1943 Lt. (j.g.), Lt. May 1944; Service Terminated January 1946; Duty —San Juan, P. R.; Miami, Fla.; Curtis Bay, Md.

GOMPERTZ, MICHAEL L., New Haven (Entered service from New York City); b. 1912; Columbia 1937; Army Air—December 10, 1942 Lt., Captain April 1944; Service Terminated January 1946; Duty—School of Aviation Medicine, Randolph Fld., Tex.; Santa Ana, Calif.; Southwest Pacific; Awards—Asiatic-Pacific Ribbon w/4 battle stars.

GOODELL, ROBERT A., Hartford; b. 1902; Harvard 1928; Navy—November 17, 1943 Lt. Comdr., Commander November 5, 1945; Service Terminated

April 24, 1946; Duty—Chemical Warfare School; Newport. R. I.; Lido Beach, L. I., N. Y.; Shoemaker, Calif.; Okinawa; USS Samaritan; Sasebo, Japan (Asiatic-Pacific Theatre of Operations); Award—Unit Citation.

GOODRICH, WILLIAM A., Hartford; b. 1909; Columbia 1935; Army—September 1942 Lt., Captain April 1943; Service Terminated September 1943; Duty—Camp Bowie, Tex.

GOODRICH, WILLIAM J., Bridgeport.

GOURLIE, HOWARD W., Thompsonville; b. 1905; Harvard 1931; Army—September 24, 1942 Captain, Major June 6, 1944, Lt. Colonel June 12, 1946; Service Terminated October 10, 1946; Duty—Carlisle Barracks, Pa.; U. S. Military Academy, West Point, N. Y.; Award—Army Commendation Ribbon.

GRADY, JOSEPH F., New Haven; b. 1905; Columbia 1932; Army—September 29, 1942 Captain; Service Terminated July 20, 1946; Duty—Desert Training Center, West Coast; England-Germany (European Theatre of Operations).

GRANOFF, MAURICE A., New Haven.

GRAYSON, MERRILL, New London.

GREENE, GERALD S., Rocky Hill; b. 1914; Harvard 1939; Navy—August 18, 1942 Lt. (j.g.), Lt. October 1944; Lt. Comdr. December 1945; Service Terminated February 17, 1946; Duty—Sub. Base, New London, Conn.; Portsmouth, Va.; USS Baltimore (European and Asiatic-Pacific Theatre of Operations); Jacksonville, Fla.; (Removed to Massachusetts).

GREEN, ROBERT H., New Haven.

GREEN, WILLIAM F., Newtown; b. 1906; Harvard 1932; Navy—July 7, 1941 Lt., Lt. Comdr. March 1, 1943; Service Terminated October 20, 1945; Duty—Mobile Hospital #2, Pearl Harbor, T. H.; Bainbridge, Md.; Pensacola, Fla.; Jacksonville, Fla.; Awards—Pearl Harbor Combat star.

GREENSPUN, DAVID S., Bridgeport; b. 1899; Yale 1925; Army—September 30, 1942 Captain; Service Terminated September 27, 1945; Duty—Camp Shelby, Miss.; School of Clinical Pathology, Ann Arbor, Mich.; Carlisle Barracks, Pa.; European Theatre of Operations.

GREINER, GEORGE F., Kent; b. 1911; Vanderbilt 1940; Army Air)—September 13, 1941 Lt., Captain December 24, 1941; Service Terminated February 1946; Duty—School of Aviation Medicine; Ft. Dix, N. J.; Caribbean and Central American Theatres of Operation; Continental United States.

GRENDON, DAVID A., Kent (Entered service from New York City); b. 1903; Harvard 1928; Army—November 16, 1942 Captain, Major August 1944, Lt. Colonel January 1946; Duty—Walter Reed General Hospital, Washington, D. C.; Gorgas Hospital, Canal Zone; Award—Army Commendation Ribbon.

GRIGAS, JOHN E., Greenwich; b. 1911; Tufts 1936; Navy—June 1942 Lt. (j.g.), Lt. May 1, 1943; Service Terminated August 1, 1945; Duty—Sub. Base, New London, Conn.; Amphibious Force (Atlantic); 4th Marine Division; San Diego, Calif.

GUALTIERI, MICHAEL V., Waterbury; b. 1918; Tufts 1943; Navy—October 10, 1944 Lt. (j.g.); Service Terminated June 22, 1946; Duty—St. Albans, N. Y.; USS Ordronaux; USS Pollux; Oakland, Calif.; Alameda, Calif.

GUDGER, JAMES R., Hartford; (Removed to New York).

GUIDA, FRANCIS P., New Haven; b. 1909; Yale 1934; Navy—May 10, 1943 Lt., Lt. Comdr. October 5, 1945; Service Terminated March 2, 1946; Duty—U. S. N. Hosp., St. Albans, N. Y., Naval Disp., St. Thomas, V. I.; Naval Disp., (Air) San Juan, P. R.; U. S. N. Hosp., Great Lakes, Ill.

GULASH, JOHN R., Bridgeport.

GURWITZ, JACK, Newington (Entered service from Brookline, Mass.); b. 1912; Tufts 1938; Army—January 2, 1941 Lt., Captain, February 1, 1942, Major March 1, 1945; Service Terminated November 4, 1945; Duty—Camp Edwards, Mass.; Ft. Devens, Mass.; Pine Camp, N. Y.; 93rd Evacuation Hospital—Ft. George Meade, Md.—North Africa-Sicily-Italy-France-Germany; Awards—5th Army Letter of Commendation; Bronze star; Meritorious Unit Placque; 2 Arrowheads; 7 combat stars.

HABERLIN, CHESTER E., Stratford; b. 1899; Virginia 1924; Army—February 24, 1941 Lt. Colonel, Colonel March 30, 1943; Service Terminated July 9, 1946 Brigadier General; Duty—Camp Blanding, Fla.; 4th Army—Louisiana Maneuvers; 1st Army—Carolina Maneuvers; Camp Shelby, Miss.; Ft. Bragg, N Camp Kilmer, N. J.; Egypt; Eri Palestine; Iran Camp Gordon John Fla.; Camp Barkley, Tex.; 174th eral Hospital—191st General Hos Camp Miles Standish, Mass., Engl Scotland-France; 280th Station Hos Cherbourg, France; German P. W. pitals on Conton Peninsula (Euro Theatre of Operations); Walter General Hospital, Washington, D. C

HAINE, JOHN W., Stamford (Ent service from Lakewood, Ohio); b. 1 Union University, Albany Medical lege 1943; Army—October 1944 Captain June 17, 1945; Service Te nated January 8, 1947; Duty—Car Barracks, Pa., Camp Gruber, Okla.; 1 Evacuation Hospital, Duisberg, Germ 777th Feld-Lazarette and Herz- Krankenhaus, Lindlar, Germany (E pean-African-Middle-Eastern Theatre Operation); Billings General Hosp Indianapolis, Ind.; Ft. Knox, Ky.; Aw —Bronze battle star.

HAINES, HENRY L., New London (tered service from Baltimore, Md.) 1911; Johns Hopkins 1939; Navy— tember 9, 1944 Lt. (j.g.), Lt. June 1 Service Terminated September 26, 1 Duty—Sub. Base, New London, Co Medical Research Assigned to U U873, R-6, New London, Conn.; Aw —Letter of Commendation.

HALIDAY, EARLE G., Stonington; 1903; Queens 1927; Army Air—Aug 30, 1942 Captain, Major November 1 Service Terminated February 20, 1 Duty—Zone of Interior; New Gui Biak, N.E.I.; Mindoro, Luzon, P. Okinawa; Japan; Awards—Air Me Asiatic-Pacific Ribbon w/6 Bronze ba stars.

HALL, WENDELL C., Hartford; b. 19 Pennsylvania 1930; Army Air—Febru 3, 1943 Major; Service Terminated Ma 1945; Duty—Miami Beach, Fla.; Regio Hosp. #1, Coral Gables, Fla.

HALL, WILLIAM E., Meriden; b. 19 Yale 1925; Navy—September 16, 1 Lt. Comdr., Commander August 12, 19 Service Terminated January 18, 19 Duty—Brooklyn, N. Y.; Norfolk, V Bronx, N. Y.; Rheumatic Fever U Corona, Calif.

HAMILTON, JOHN S. M., Stamf (still in service).

(To be Continued)

OBITUARIES

Charles Coffing Beach
1856 - 1948



Dr. Charles Coffing Beach was born in Hartford, Connecticut, May 19, 1856 and died at his home in Hartford on February 11, 1948. He was the son of the late Joseph Watson Beach and Josephine Elizabeth Coffing Beach and a grandson of George Beach, one of the early presidents of the Phoenix State Bank. He attended private schools and Hartford Public High School. In 1877 he graduated from Yale College with a keen interest in chemistry and entomology. Thus it was natural for him to enter the employ of his father's company where he did analyses in chemistry for that concern. However, his interest in medicine was strong and he soon matriculated in the College of Physicians & Surgeons, Columbia University, New York City, from which college he received his medical degree in 1882. After graduation he spent two years at St. Luke's Hospital in New York City, and following this went to Europe for further study in Berlin and Vienna. It was during this time that he became acquainted with Sigmund Freud who at that time had not begun his work in psychiatry but was giving lectures in medical and surgical studies of the brain, writing in German but delivering his lectures in beautiful English. Returning to this country, Dr. Beach began the practice of medicine in Hartford and remained in active practice for over sixty years. He was one of the early police surgeons and attending physicians at Hartford Hospital. He had a strong attachment for the natural sciences and did a great deal of research in literature pertaining to them, contributing articles to many scientific publications. He also had an active interest in languages and the arts.

His wide interests brought Dr. Beach membership in a variety of clubs and organizations. He was a past president of the Hartford Medical Society and had memberships in Hartford County Medical Association, Connecticut State Medical Society, American Medical Association, Farmington Country Club, Hartford Golf Club, University Club, Yale Club of New York, St. Anthony's Club of New York. He was a 32nd degree Mason, a member of St. John's Lodge, Pythagorus Chapter and Wolcott Council in Hartford, Connecticut. He served as vestryman and warden of Christ Church and the Chapter of the Cathedral. He was a member of the American Museum of Natural History and the New York State Zoological Society.

Dr. Beach was a distinguished figure, one of the great men of the Travelers Insurance Companies. At the time of his passing he was the senior member of the Board of Directors, a member of that board for fifty-eight years, Consulting Medical Director for forty years until his retirement about a year ago. His sage counsel and friendly greetings will be greatly missed by the Travelers Family. He was a son-in-law of its founder, James G. Batterson. Sixty-three years ago Dr. Beach married Mary E. Batterson who survives him. He also leaves three sons, Goodwin Batterson Beach, Joseph Watson Beach and Charles Bradford Beach, one daughter, Mrs. Elizabeth Goodwin Beach Capen, thirteen grandchildren and eight great grandchildren.

Dr. Beach kept in tune with over three-quarters of a century of progress in multiple lines of endeavor. As a young boy he saw people embark for service in the Civil War and more recently saw his sons and grandsons return from World War II. In his ninety-two years I doubt if he seldom experienced a dull moment.

Thomas H. Denne, M.D.

George Washington Dunn, M.D.
1888 - 1948



Dr. George Washington Dunn was born on February 22, 1888; reared and schooled in Southington, Connecticut, to which he remained attached through his life. He attended the University of Maryland Medical School, graduating cum laude in 1909 at the age of 21 and as the fifth highest scholar of his class. After two years of internship at St. Francis Hospital, Hartford, he started practicing in New Britain. Immediately he was appointed assistant surgeon on the staff of the New Britain General Hospital. Two years later at the age of 25, in recognition of his abilities he was elevated to attending surgeon. In 1925 he became the chief of staff; and after 20 years of most competent stewardship he resigned his post in 1945.

Through the years he attained an outstanding reputation locally and through the state as a surgeon. Like many great surgeons of his day he was a self-trained man. His medical wisdom, sound surgical judgment, and his fine operative technique came as a result of a keen mind, natural adaptation, diligent application and practical experience which he developed through great courage. He was first in New Britain to become a member of the American College of Surgeons and the first to be certified on reputation by the American Board of Surgery.

Through the years he held a very influential position in the New Britain Medical Society, which he served as president and on various committees. Similarly, in county and state medical affairs, his quality of leadership, deep interest in cause of good medicine, and efficient organization were recognized. He served as president, chairman and member of several important committees of the Hartford County Medical Association.

In county and state medical circles he symbolized New Britain. In public mind he was held in high esteem. His patients idolized him; his friends admired him; and his medical colleagues tried to emulate him even to the point of adopting certain of his ways and mannerisms.

He served his community in a hundred and one ways; some purely medical, others civic and still others charitable. He had many social and fraternal affiliations including New Britain Lodge of Elks, Shuttle Meadow Club, and as a member of the Bishop Tierney Assembly, Fourth Degree, Knights of Columbus. In all these organizations he stood out as he did in his profession. He was an active member and great supporter of the young and dynamic St. Maurice Catholic Church.

In spite of his busy and responsible professional life he lived well and enjoyed his various pursuits and interests such as, golfing, fishing, traveling and good fellowship.

It is difficult to truly represent in words the great services to the community of a great man or to evaluate his influence on medicine in New Britain in his lifetime and thereafter, through the lives of others. Every doctor in New Britain felt, in small or great measure, the influence of Dr. George W. Dunn. Loss of such a great leader is truly a grevious one. His departure on January 31, 1948 left a great void in the medical scene and every section of life in New Britain has missed him sorely; yet, in his departure he leaves a shining example for others to follow as a fine man, an outstanding surgeon and a true leader. For many years he shall live in pleasant yet sad memory of his colleagues, friends and patients.

He is survived by his wife, Elizabeth Purney Dunn, a daughter, a son, two daughters and a granddaughter from his first marriage to Isabella Martin Dunn.

Philip J. Moorad, M.D.

Arthur Sheldon Grant, M.D.
1880 - 1947



Dr. Arthur Sheldon Grant was born in South Windsor on November 9, 1880. Following graduation from Wesleyan he attended New York University School of Medicine (Bellevue) from which he graduated in 1908. After a period of general practice in Waterbury and later in South Windsor he entered military service during the first World War as a First Lieutenant in the Medical Corps. With hostilities over he remained with the Army of Occupation in Germany. There he developed his interest in x-ray; and after discharge in 1919 he completed his training at Cornell. Then he came to New Britain and took the post of the first radiologist in the New Britain General Hospital. He organized the department and established it on a modern and efficient basis.

In 1927 he left this position to enter private practice of radiology which he continued until his death. During the years 1940 through 1945 he was in charge of the radiological services in the Bristol Hospital. He held membership in his local, county, state and national medical societies; was a Fellow of the Radiological Society of North America since 1921; and a member of the American Roentgen Ray Society. He served the New Britain Medical Society in various capacities.

He had many civic and club interests being a member of the New Britain Club, New Britain Choral Society, and the American Legion. As a charter member he was active and loyal in the Kiwanis Club and served on its Board of Directors. Because of his interest in youth he was chairman of the Under-Privileged Child Committee of that organization. For a long time he was identified with the Boys Club of New Britain. He was an active member and former deacon of South Church, Congregational. He survived a very severe heart attack in May 1947 and many minor ones during the hospitalization that followed, finally making complete recovery and returning to the x-ray work he loved so much. It was in the conduct of this work that the final attack came which led to his demise on December 11, 1947.

Dr. Grant was a very quiet, genial, unassuming, modest and loveable man. His ways and manner indicated serenity within, general harmony with life, and peace with his fellow men. His family ties were very strong and he loved them well. He is survived by his wife, Mrs. Marion Pitkin Grant; a daughter, Dr. Constance L. Grant, physician to New Britain Schools; a brother, Judge Ralph M. Grant of East Windsor; and a sister, Mrs. Clarence Smith of Inglewood, California.

Philip J. Moorad, M.D.

Harry Eaton Stewart, M.D.
1887 - 1948



Harry Eaton Stewart died on January 6, 1948. He was a native of Missouri, having been born in St. Louis of early American stock. In early child-

hood, however, his family came to New Haven and Harry was kept busy while in grade school with small jobs in order to help make ends meet. He attended Hillhouse High School where he was on the swimming, track, and basketball teams through the entire 4 years. In addition to these activities he managed to do part time work tending furnaces and running errands for Yale students.

In those days it was common procedure to go directly from high school to medical school, so on graduation from Hillhouse in 1906 he entered Yale Medical School. Here he continued to be very active in athletics as a member of the basketball, swimming, and gymnastic teams until a faculty ruling made it impossible for a medical student to take part in intercollegiate competiton. He continued active, however, in the gymnasium as an instructor under the late Dr. William Gilbert Anderson. As a result of this association, Harry became deeply interested in the relation of athletics to medicine, this interest remaining for many years. He was graduated in medicine in the class of 1910 and started practice in Washington, Connecticut, with an older physician in a far flung country practice.

Harry liked to reminisce over that period of the many experiences with a balky horse, the mud, the train rides with a patient in the baggage car, and the inevitable races on horseback to beat the stork. While in Washington he acted as physician and coach at the Wykeham Rise School for girls. At that time he published several articles on the effect of exercise on blood pressure, and cardiac function.

In 1916 he returned to New Haven, becoming associated with the late Dr. E. H. Arnold in orthopedics and at the New Haven Normal School of Gymnastics, later Arnold College.

He entered service in 1918 and was very shortly assigned to the Surgeon General's office in the newly created section of Physical Therapy as assistant director under the late Colonel Granger. At the end of the war he was transferred to the USPHS and then, when it was formed, to the Veterans Bureau, with the primary duty in all three instances of organizing physical therapy facilities. Harry was discharged in 1919 with the rank of Major, and a request by Colonel Carr that he set up a training school for technicians.

Being a good soldier this request was carried out and the New Haven School of Physical Therapy came into existence. It grew under his guidance through the years and the depression from a course of a few weeks to a year, and finally in 1940 to a Junior College. In this manner Harry trained several hundred technicians, and over 50 physicians, several of whom are now nationally prominent in physical medicine.

During the war and following his return to civilian life he developed his technique with diathermy in pneumonia which won him an international reputation, the Royal College calling him to London to present a paper on the subject in 1924.

This was not his first trip abroad, however, since he took the first American Women's track team to Paris in 1922 where in international competition they broke 4 world marks and 8 American records. In this instance Harry again acted as physician and coach.

One of his later contributions to Connecticut was the establishment of legal control of physical therapy technicians, through examination and registration by the State Board of Health. This placed Connecticut second only to Pennsylvania.

Harry was a man always ready and willing to fight for what he thought was right. Those who knew him well have some idea of the battles he has faced and won but probably none of us can fully appreciate the effort expended. He worked hard and played hard, and in the course of his travels made many warm and loyal friends. He gave unstintingly of himself and was rewarded with a very rich life.

In 1910 in New Haven he was married to Grace M. Stuart, who with a daughter and two grandchildren, survive him.

Dr. Stewart was an active member of New Haven Medical Association, New Haven County, and Connecticut State Medical Societies; chairman of the Section of Physical Therapy of the State Society; Fellow of the American Medical Asociation; member of the American Congress of Physical Medicine, Academy of Physical Medicine, New York Society of Physical Medicine; attending specialist in Physical Medicine for Veterans Administration; member of the Connecticut Rehabilitation Association, Reserve Officers Association, Foot Guard, Honorary Reserve of Officers Reserve Corps, and a 32nd Degree Mason.

John C. Allen, M.D.

CORRESPONDENCE

Complex Simple Fracture

To the Editor:

Realizing that the term "simple fracture" as generally defined is thoroughly inadequate to describe the trauma received in many so-called simple fractures, I have added a new definition to the simple and compound fracture nomenclature, i. e., "complex simple fracture" (Key, J. A., and Conwell, H. E.: The Management of Fractures, Dislocations and Sprains, ed. 4, St. Louis, C. V. Mosby Company, 1946, pp. 41-43).

A complex simple fracture is a fracture which is not compound but which has received severe trauma to either or all of the surrounding soft structures, i. e., skin, muscles, blood vessels and nerves. The bony fragments usually are displaced to a marked degree.

"Complex," as defined by "Webster's New International Dictionary," unabridged, is as follows: (1) an assemblage of related things; (2) a whole made up of complicated or interrelated parts.

The complex simple fracture should be further described as to the type of bony injury: for example, complex simple fracture (transverse, comminuted, spiral or oblique, as the case may be).

Through personal contacts and correspondence with the personnel of the three National Fracture Committees (American Medical Association, American College of Surgeons and American Academy of Orthopaedic Surgeons) with reference to their opinions and the necessity for such new fracture term or definition, there was unanimous agreement that such a definition of complex simple fracture was a necessary one and should be generally accepted and used in its broad meaning.

I make an appeal that this new fracture definition or its relative equivalent be used by the members of the medical profession. Besides expressing more adequately the pathologic process in such type fracture it will mean improved records for the hospitals and convey a better description of the fracture to the insurance companies, compensation boards and other related agencies, thereby being of much help to the patient, the physician and every one concerned.

I will appreciate any opinion or suggestions relative to the foregoing.

H. Earle Conwell, M.D.,
Birmingham, Ala.

Reprinted from the Correspondence Department of The Journal of the American Medical Association, October 25, 1947, Vol. 135, p. 531, at the request of the author

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Veterans Administration

March 24, 1948

To the Editor:

I am enclosing copy of a self explanatory letter which was sent to Dr. Morris Fishbein, editor of the *Journal of the American Medical Association* by Dr. Paul B. Magnuson, Chief Medical Director, Veterans Administration, Washington, D. C., in reference to a new Veterans Administration program.

Under this program, as Dr. Magnuson's letter indicates, it will be possible for doctors who have completed approved formal residencies in medicine, surgery and neuropsychiatry to complete the qualifications of their specialty board examinations through supervised practice in their chosen specialty as full time Veterans Administration employees.

Some vacancies exist in New England. Many more exist in other parts of this country.

I should like to request that the information contained in this letter and that of Dr. Magnuson be given widespread publicity by the Medical Society.

Francis B. Carroll, M.D.,
Branch Medical Director

March 9, 1948

Dear Dr. Fishbein:

I take this means of informing you and the thousands of young resident physicians throughout the country of a new Veterans Administration program regarding specialty practice in Veterans Administration hospitals for residents who have finished three years of formal training at an outside institution. Under this program, it will be possible for doctors who have completed approved formal residencies in medicine, surgery and neuropsychiatry to complete the qualifications of their specialty board examinations through supervised practice in their chosen specialty as full time Veterans Administration employees. It is only in these three special-

ties that we have thus far had assurances of approval by the boards. This arrangement is in operation for residents being trained within the Veterans Administration and is now being extended to offer this opportunity to those residents receiving their formal training at other than Veterans Administration institutions.

Let me point out that in general the specialty boards as a whole require that at least 80 per cent of a candidate's practice be devoted to a specialty for at least two years after completion of his three year formal residency training. I know of no place in the country, other than Veterans Administration hospitals, where a man can practice 80 per cent of the time in a specialty immediately after finishing a three year residency. I certainly did not confine my own practice to even 50 per cent surgery during those first two years because I had to eat. I think most of the young physicians are in the same boat.

For this program, our standards are similar to those of the American Medical Association. We require candidates to be citizens of the United States, graduates of approved medical schools in this country or Canada, to have completed an approved internship and three years of approved formal residency training in a chosen specialty. The successful applicants will have full opportunity to obtain the type and amount of specialty practice required of candidates for certification.

At a recent meeting with board representatives in Chicago, we agreed that in those hospitals where there is not a board certified, full time Veterans Administration physician to supervise the residents' activities, the Veterans Administration would arrange for a consultant in the appropriate specialty to check on the residents' work at least once a month and serve in a liaison capacity between the American Boards and the resident. In other words, there will be thorough and complete supervision and guidance of each man's work.

It might be impressed on these young physicians that, in general, the hospitals which will participate in this plan are not located in cities where teaching institutions are now connected with the Veterans Administration. This is a program which will take specialty training out into the hospitals where we do not have close affiliations with medical schools, although all of the supervising consultants will be connected with medical schools. It will present a definite challenge to these men and will provide an opportunity for them to prove their ability in their chosen field. Although the men need not expect to have separate operating crews at their disposal, or all the assistants a chief has, they will be expected to practice good medicine. In some cases, if a man is good, he might even be made chief of his service in a small hospital. At any rate they will have from five to ten times as many cases in their respective specialties as they would probably have in a private or university hospital under existing conditions. It should also be pointed out that all of our neuropsychiatric hospitals have many general medical and surgical beds, which means a wider opportunity and a greater range of cases than might otherwise be expected.

We have some other very obvious advantages to offer men who are seeking proper preparation for the specialty board examinations. In the first place, the Veterans Administration is emphatically not a military institution. A man can come in today and resign tomorrow if he so chooses. We are convinced that the hospital program we are trying to develop can become the greatest medical service organization in the world and we are open to suggestions and constructive criticisms at all times.

We hope that a fair percentage of these physicians will find the service so satisfying that they will want to stay with the Veterans Administration after they have completed their board requirements, at least until they have earned sufficient reputation to cause some medical school or other institution to want them for what they may consider broader fields. We can offer these men full time Department of Medicine and Surgery staff appointments. We will take them on in junior, associate, full or intermediate grades, depending upon their qualifications. They will receive annual salaries of $4,149.60 in junior grade, $4,902 in associate grade, $5,905.20 in full grade and $7,102.20 in intermediate grade.

Another very decided attraction is the fact that it is possible we may be able to provide quarters at some of the outlying stations at a very modest rate. It must be emphasized, however, that this is completely dependent upon each local situation. Rent for housekeeping quarters at these stations generally runs from $40 to $57 per month. Where else can a man get quarters for his family at such low cost these days? Where possible, we shall try to assign these doctors to hospitals of their choice. In all cases, their wishes will be given every possible consideration. In other words, this is what I consider an ideal opportunity for the young man with a

family who wants to complete his training, give the best type of service and at the same time make a living for his family.

I should like to have this message made known to all residents outside the Veterans Administration. We are going to lose some 1,400 or 1,500 ASTP and V12 trained physicians by July 1 and, for that reason, we are prepared now to accept applications. Candidates should apply well in advance of the date of availability in order to avoid delay in processing. Their applications must be sent directly to the Branch Medical Director of the VA branch areas in which they are interested. The 13 Branch Offices are located at Boston, New York City, Philadelphia, Richmond, Atlanta, Columbus, Chicago, St. Paul, St. Louis, Dallas, Seattle, San Francisco and Denver. No street addresses are needed. We are sending out notices to our Branch Medical Directors requesting that they appoint someone in their offices to interview each applicant. If there are no places available in the branch to which application is made, each man will be so notified and his application will be forwarded to Washington for possible assignment in another area. I want to emphasize that if any applicant does not receive an acknowledgment within a week or ten days, it does not mean we do not want him. These things take a little time and they may be assured that we will process each application just as rapidly as possible. The telephone numbers of these branch offices will be found in the city telephone directory under U. S. Government, Veterans Administration. Applicants should ask for the Branch Medical Director or his designate.

Paul B. Magnuson,
Chief Medical Director

World Health Organization

April 7, 1948

To the Editor:

Word came this evening that three more countries have just deposited their ratifications of the constitution of the World Health Organization. They are Byelo-Russia, Mexico and the Ukraine. They make twenty-seven nations in the U. N., and the World Health Organization comes into being. Eight non members of U. N. have ratified also, making thirty-five countries that are now members of the new WHO.

The United States is not one of them. Something over two years ago our Congress invited the nations of the world to meet in New York to draw up the constitution of such an organization. They did, in the summer of 1946, and on the last day sixty-one signed preliminary acceptance. In July 1947 our Senate approved the constitution and our membership by unanimous vote. In the House (for it has been decided to ask approval by joint resolution rather than by ratification of a treaty) the Foreign Affairs Committee unanimously recommended approval. On March 12, 1948 the Rules Committee of the House tabled the motion to permit a vote on the floor.

I am not going into the arguments for a world health organization, or for any world organization, for that matter. They are well summed up in an editorial from the *Journal of the American Medical Association,* a copy of which was on my desk today.

I am thinking rather of the arguments which we have unwittingly placed in the hands of people who do not like our country. Their agents will be saying to countries on the fringe, who may be a bit doubtful which way to turn these days: "That is just what we have been saying of the United States. They will start anything. They will get you interested; then you look around and they are not anywhere to be seen. Can you depend on a country like that to stay by you?" Whether that is true or not, we have certainly given these gentlemen excellent talking points.

The constructive thing is that disease knows no borders. We doctors know that, and we have learned to work together.

In the hope that the House may be persuaded to take action before the first session of the Health Assembly, in June, can you and the JOURNAL take such action as seems most suitable and helpful?

Henry R. O'Brien

Write your Representative today asking for ratification of WHO [Editor].

The Pediatrics Survey

March 15, 1948

To the Editor:

At its meeting in Washington on July 7 and 8, the Executive Board of the American Academy of Pediatrics reviewed in detail the work of the Survey

Committee and its executive staff. The monumental task of collecting factual data from every state in the Union is now well on its way to completion. The Academy feels greatly indebted to its State chairmen, their executive secretaries, and to all the other individuals and organizations to whose cooperative efforts at the state level belongs a major share of the credit of the success of the Survey.

The State chairman of Connecticut has informed this office of the valuable assistance rendered by the CONNECTICUT STATE MEDICAL JOURNAL, and we take this opportunity to thank you on behalf of the entire Academy. It is our belief that this effort on the part of physicians to inform themselves accurately concerning the medical facilities and services or their lack for the children of America can be the basis for a constructive program for the improvement of child health throughout the nation. Obviously much remains to be done if the statistical material which is being collected and processed is to reach its maximum effectiveness. Sometime within the next few months each state will have the facts as they exist within their own borders. Based upon these facts, a state report will be prepared. It is hoped that the individual states will then undertake active programs based upon their own needs as demonstrated by the Survey. Looking ahead to this time we would enlist your further support and cooperation in the same manner as has been done during the conduct of the Survey.

The Academy is justly proud to be the sponsor of a program which has received such wholehearted cooperation from so many individuals and groups. Its reward will come if out of these combined efforts a better way of life can be secured for the children of America.

John A. Toomey, M.D.,
President

Clifford G. Grulee, M.D.,
Secretary-Treasurer

State of Connecticut Food and Drug Commission

March 29, 1948

Circular letter to All Physicians

Dear Doctor:

In the midst of the general agitation throughout the United States for more restrictive laws relative to the sale of hypnotics, we wish to again request your aid in our enforcement of Section 901e, subsection K, of the Connecticut Food, Drug and Cosmetic Act concerning the sale of certain drugs restricting their sale to the written prescription of a physician, dentist or veterinarian and prohibiting the refilling of such prescription except on the written or oral order of the physician, dentist or veterinarian.

The subsection referred to reads:

A drug or device shall be deemed to be misbranded:—(k) if it shall be a drug sold at retail for use by man and shall contain any quantity of amidopyrine, barbituric acid, cinchophen, dinitrophenol, sulfanilamide, or thyroid or any derivative of any of these substances, unless it shall be sold on a written prescription signed by a member of the medical, dental or veterinary profession who is licensed by law to administer such drug, and its label shall bear the name and place of business of the seller, the serial number and date of such prescription and the name of such member of the medical, dental or veterinary profession. No such prescription shall be refilled except upon the written or oral order of the physician.

The penalty for violation of this section is placed at imprisonment for not more than six months or a fine of not more than $500 or both, and the pharmacist is, of course, anxious to avoid any violation of the law.

You can materially assist him in this endeavor and the state in its enforcement of the law—thus protecting your patient and keeping control of the case where it should be, with you—by cooperating with the pharmacist.

This can be done in two ways: by marking your prescription as not to be refilled or by designating how many times it may be refilled, or, if you have failed to so mark the prescription, by welcoming the pharmacist's call when he asks if a prescription calling for any of the mentioned drugs may be refilled.

We believe that cooperation between the physician and the pharmacist will do much to make more restrictive laws—which might include the keeping of voluminous records—unnecessary.

Trusting that we may receive this cooperation from you, I am

F. H. Holbrook,
Food and Drug Commissioner

ANNUAL REPORTS

REPORT OF THE TREASURER

Details of the financial activities of your Society for the fiscal year of 1947 appear in the report of the Auditors elsewhere in the Agenda. This report deserves the careful scrutiny of every member of the Society for two reasons.

First, it will be evident that the Society operated within its budget; and second, that its operations were conducted for the increasing benefit of its members and for the promotion of good medicine in Connecticut. Further, it should take but little thought, in contemplation of these figures, to conclude that the membership got "full value received" for these expenditures.

That the members of the Society are aware of its importance to them is indicated by the promptness with which they pay their dues. For the year 1947, less than one per cent of a total membership of approximately 2400 were delinquent; and by March 31st, over 75 per cent had paid dues in full for 1948.

This happy situation also reflects the efficiency of the staff in the office of the Executive Secretary where dues for six counties are collected and also that of the Treasurers of the two other counties who collect for the state Society.

Your previous Treasurer, Dr. Campbell, and the Executive Secretary, Dr. Barker, deserve commendation for the establishment of effective financial and accounting procedures in the central office. The Society, too, is grateful for the continued high quality of the services performed by the Second National Bank of New Haven and our auditors, Seward and Monde.

The 1947 budget estimates indicated a probable excess of approximately $2000 of income above expenditures. Actually, as a result of increased income and underspending the budget, a net favorable excess of $3941.15 resulted.

The budget for 1948 is much more constricted, estimating that the necessary expenses for operation this year will be within $945 of total estimated income. In these days when prices show little tendency to decline, it must be admitted that even with the most careful scrutiny by the Finance Committee, actually the Council, to remain within the budget will require delicate balancing. Obviously, on the basis of current income, little thought can be given to expansion of present or development of new activities of the Society.

Respectfully submitted,
Cole B. Gibson

REPORT OF THE EDITORIAL BOARD OF THE CONNECTICUT STATE MEDICAL JOURNAL

Stanley B, Weld, *Editor-in-Chief*
Herbert Thoms, *Literary Editor*
Frank S. Jones
Paul P. Swett
Benjamin V. White
Harold S. Burr, *Associate Member*

Mr. President and Members of the House of Delegates
Gentlemen:

Having entered upon the second decade of our existence and passed more than a year in this new age bracket, it is an opportune time to reflect on our past and philosophize a bit on our future. There is no doubt in my own mind that the JOURNAL has come a long distance since that first issue in August 1936. We all may point with pride to the instance at the last Secretaries-Editors Conference in Chicago when the chief engineer of the Waverly Press in Baltimore designated the CONNECTICUT STATE MEDICAL JOURNAL as the outstanding publication among the State medical journals because of its typography, legibility and attractiveness. All this is gratifying to your editors and should be to every member of our Society. It is very easy to rest on one's laurels but no publication, as no individual, can remain a leader unless there is constant improvement.

Durnig the year 1947 the Committee to Study the Organization of the State Society focussed attention on the JOURNAL through a questionnaire distributed to all our members. In this questionnaire the committee attempted to evaluate reader interest. Replies were received from approximately one-third of our membership, a good return as questionnaires go. Some interesting facts were disclosed. First it was learned that 91 percent of our members replying do read the JOURNAL in whole or in part. There was an equal demand for more material from our own members as well as for more articles from national figures. A large percentage of returns expressed no interest in the news of the Woman's Auxiliary. Had this been worded to show interest in the Auxiliary or the Auxiliary section of the JOURNAL and not in news about the ladies we felt quite certain there would have been more favorable returns. An interesting fact disclosed was the number (about 50 percent of the replies in each instance) who use the book reviews in selecting books and the advertising pages in selecting drugs and supplies.

The questionnaire replies indicated a general desire for more clinical scientific papers. This is a healthy sign because this desire can and should be met by our own members. Manuscripts from Connecticut physicians are on the increase and during 1947 published manuscripts of our members outnumbered those from out of state physicians almost two to one.

Questionnaire returns showed an agreement with editorial opinions expressed by 87 per cent. However, it has been said by some (who may not have replied to their questionnaire) that the editorial tone of the JOURNAL is too conservative. This may be true and is more consistent with the attitude of our Society which welcomes an expression of opinion from both sides of a question, while reserving the right of judgment to the quiet of its own cloistered walls. From the summary of the committee's findings as a result of the questionnaire, I quote: "The presentation of clinical articles and material has been and should continue to be the primary objective of the Editorial Board." During the year 1947, 33 of our members submitted articles which were published. 11 of these were case reports. This is encouraging but we should receive more of the results of our own members' experiences.

Special articles during the year have dealt with the care of the chronically ill, health in education, the medical pro-

gram at Newington Veterans Hospital, the rooming-in plan in the New Haven Hospital, the operation of Public Law 725, the diagnostic clinic, voluntary prepaid plans in rural communities, and the Connecticut cancer registry. Editorials have covered a wide range of subjects from prepaid medical care plans to rising hospital costs on the one hand, and from streptomycin in tuberculosis to breast feeding as a clinical and social problem on the other. Several editorials have been devoted to the nursing problem and our readers have been edified by the writings of one of our non resident members, G. B.

The two presidents have presented the issues of the day in the monthly "President's Page." "The Secretary's Office" continues to keep you informed of some of the details of the vast amount of business transacted by Dr. Barker and his assistants. In the other departments an effort has been made to give the members of our Society a summary of what is transpiring in Washington, in the Veterans Administration, in our own State Department of Health, and in our Woman's Auxiliary. Our county news editors deserve commendation for the improvement shown in this department during 1947.

The advertising of the JOURNAL is directly linked with its finances. During 1946 our receipts from advertising, subscriptions, reprints, etc., enabled the JOURNAL to realize a substantial profit. This would have been the case in 1947 also had not the costs of production increased by leaps and bounds. As it was the actual cost of the JOURNAL to the Society amounted to approximately $1.00 per member. Every effort is being made to keep this at a minimum but the outlook for 1948 is clouded by smaller advertising budgets in most of the large pharmaceutical companies. This is reflected in smaller contracts for the State medical journals and hence a diminished income. The quality of the JOURNAL will be maintained at its present high level in spite of fluctuations in the advertising market. Reader interest should determine the wisdom of this policy.

The mechanics of the JOURNAL have continued to move smoothly during the past year. The Board now meets quarterly and to these meetings are invited the county news editors, the State Society director of public relations, Mr. James Burch, the publicity chairman of the Woman's Auxiliary, and from time to time members of the office staff and our printer, Mr. Donald Bullis. There exists the finest spirit of friendly cooperation and willingness to work on the part of each individual associated with our publication. I find my share of the work more enjoyable each year because of this.

The future of the JOURNAL rests with every member of this Society. There is a demand for more scientific material from every one of you. Our membership of almost 2500 includes many who are doing outstanding work in their fields. This material should be published and in our own JOURNAL, of course. Our JOURNAL goes into many countries across the seas and is used for reference by many a foreign student and scientist. It is the aim of your editors to continue to improve our publication in every way possible and thus assist the Connecticut State Medical Society to maintain its leadership among the profession and before the public.

Respectfully submitted,
Stanley B. Weld

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Creighton Barker Joseph H. Howard Thomas P. Murdoel

The first interim session of the American Medical Association to include meetings of the House of Delegates and a scientific session was held in Cleveland from January 5 to January 8, 1948.

Since this was more or less of an experiment, there was some uncertainty as to how many physicians would attend. It was most gratifying to note that well over three thousand registered.

The House of Delegates considered such problems as the supply of nurses, interns, and residents; hospital insurance practice and its relationship to the practice of radiologists and pathologists; rural medicine; and the development of medical care plans. The House also voted approval of the World Medical Association in which we are taking the lead, and the headquarters of this organization will be in the United States. The greater share of the funds to finance this Association will be supplied by physicians and drug houses of this country.

The Ten Point Program of the American Medical Association was again stressed, and as one reviews this plan it becomes more and more a valuable document for the improvement of medical care for the people of this republic.

The increased cost of doing business has necessitated the raising of fellowship due to twelve dollars. The price of paper, printing, and increased labor costs all enter into this entire problem. When one is familiar with the activities of the American Medical Association, the investment of twelve dollars is unequestionably small.

The section meetings and exhibits at this session were well attended. One of the highlights of the meeting was the award for the first time to the most outstanding General Practitioner in the United States. Candidates for this award may be nominated by medical societies, lay groups, or individuals, and approximately two hundred nominees were presented. After screening this large number, three men were selected as outstanding. In our democratic fashion, the House of Delegates voted for the physician whom they thought best exemplified the General Practitioner, and the winner of that award was Dr. Archer C. Sudan of Kremling, Colorado. A biographical sketch of Dr. Sudan's activities has been printed in the *American Medical Journal* and several magazines. It is not necessary, therefore, to review the contribution that Dr. Sudan has made, especially to rural medicine in a small community of Colorado.

It has been found necessary to expand the facilities of the American Medical Association, and the recommendation of the Board of Trustees to consider an addition to the present headquarters, or the building of a new home, was accepted by the House of Delegates.

A suggestion previously had been made that some method be devised for streamlining the activities of the House of Delegates. Several plans were proposed and were acceptable to the House. Considerable delay has resulted in the past because of the appointment of the Reference Committees on the first day of the meeting of the House, and resolutions proposed at that time had little opportunity for thorough study. Among the various proposals was that the Speaker of the House appoint Reference Committees in

dvance of the meeting, and that resolutions be sent to headuarters a month before the meeting of the House.

The activities of the members of our State Society deserve onsiderable recognition. Dr. Thomas Murdock was apointed by President Bortz as Chairman of the Committee o Study the Nursing Problem. Dr. Murdock presented a rogress report at this session which was received with very avorable comment, and due to his conscientious study of his very difficult situation, he and his committee will robably have a final and very constructive report ready or the annual meeting in Chicago in June. Dr. Creighton arker was appointed Chairman of the Reference Comittee on Medical Education. His experience in this field, s in others, was most valuable to the other members of is committee and to the House as a whole. As usual, he resented his report in a concise manner and helped to olve many difficult problems that were presented to his articular committee.

Finally, it is encouraging to all of us members of the Connecticut State Medical Society, to know that our proram for the admission of medical students into our Society as received national recognition, and Dr. Bortz, in his residential Address, urged that State Societies and the merican Medical Association initiate a program similar to hat in Connecticut for the admission of medical students o these organizations.

Time and space will not permit a complete report of the ctivities of the House of Delegates, and I would refer you o the *Journals* of the American Medical Associations of anuary 17 and January 24, 1948, for complete details.

Respectfully submitted,
Joseph H. Howard

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE THE CONNECTICUT MEDICAL EXAMINING BOARD FOR THE CALENDAR YEAR 1947

Charles J. Bartlett, *President*
John D. Booth — George M. Smith
Thomas P. Murdock — Wilmot C. Townsend

During the year 1947, the unprecedented activity of the Connecticut Medical Examining recorded for 1946 diminished only in slight degree. In addition to the six regular meetings required by statute, the Board held four special meetings and acted upon the second largest number of applications for certification for licensure in its history. A statistical analysis of the qualifications of the candidates and other data are a part of this report.

With the termination of the appointment of Dr. Charles J. Bartlett, the Board lost a member who had served it for more than twenty years and who for several past had been its president. Dr. Louis P. Hastings was appointed Dr. Baretlett's successor on the Board for a term of five years and Dr. Thomas P. Murdock was elected president for 1948.

In the course of the year, the Board heard charges against three physicians. The licenses to practice medicine in Connecticut of two physicians were revoked on recommendation of the Board and the third physician was exonerated of the charges.

Sixty candidates appeared for the written examinations of the Board. Of forty-three candidates who passed the examinations and were recommended for licensure, thirty-four were graduates of medical schools in the United States and Canada and nine were graduates of foreign schools. Fifty-four of the candidates were males and six were females. The list of schools represented and the number of candidates from each follows:

School	*Passed*	*Failed*	*Total*
Columbia P & S	1		1
Cornell	2		2
Georgetown	1		1
Jefferson	4		4
Laval	1		1
Long Island College of Medicine	3		3
Louisiana State University	1		1
McGill	2		2
New York University	6		6
Northwestern	1		1
Syracuse	1		1
Temple	1	2	3
Washington University	1		1
Yale	3	1	4
University of Michigan	1		1
University of Rochester	1	1	2
University of Tennessee	1		1
University of Toronto	1		1
University of Vermont	1		1
University of Wisconsin	1		1
Foreign Schools:	*Passed*	*Failed*	*Total*
American University, Beirut	1		1
University of Bologna		3	3
University of Budapest	1		1
University of Geneva		1	1
University of Havana	3		3
University of Paris	1		1
University of Pecs		1	1
Charles University, Prague		2	2
German University, Prague	1		1
University of Rome	2	3	5
University of Utrecht		1	1
University of Vienna		2	2
Total	43	17	60

Two hundred and seventeen candidates were recommended for licensure on the basis of endorsement of credentials. Two hundred and five of the credential candidates were graduates of medical schools in the United States and Canada and twelve were foreign graduates. Two hundred and two of the candidates were males and fifteen were females.

Credential candidates represented fifty-seven medical schools as follows: Columbia P & S—22, Yale—21, Harvard—13, Tufts—12, Boston University—10, Johns Hopkins—10, Long Island—10, Vermont—10, New York Medical College—9, Duke—7, Cornell—5, Georgetown—5, Jefferson—5, McGill—5, New York University—5, Albany—4, Buffalo—4, George Washington—4, with less than four candidates from each of the following schools: Temple, Loyola, St. Louis, Louisiana State, Vanderbilt, University of Chicago, University of Kansas, Ohio State, Louisville, Meharry, University of Michigan, University of Pennsylvania, University of Rochester, University of Pittsburgh, Atlanta School of Medicine, Washington University, Uni-

versity of Maryland, University of Nebraska, Chicago Physicians and Surgeons, University of Minnesota, University of Virginia, Women's Medical College of Pennsylvania, University of Arkansas, University of Tennessee, College of Medical Evangelists, University of South Carolina, Marquette, University of Illinois, University of Georgia, and the following foreign schools: University of Paris—2, Charles University, Prague—2, University of Vienna—2, and one candidate each from Konigsberg, Leipzig, London, Queens, Naples and Zurich.

Endorsement candidates presented the following credentials: National Board of Medical Examiners—120, New York—35, Maryland—10, Pennsylvania—8, Illinois—4, Massachusetts—4, New Jersey—4, Tennessee—4, Vermont—4, Kansas—3, Michigan—3, Virginia—3, Georgia—2, New Hampshire—2, North Carolina—2, Ohio—2, Arkansas—1, Kentucky—1, Louisiana—1, Maine—1, Minnesota—1, Missouri—1, Nebraska—1.

Eight examinations in medicine and surgery were given to three Doctors of Osteopathy. All three of the candidates passed the examination in surgery and two were successful in the examination in medicine.

The statistics which have been cited warrant further analysis, particular in view of the frequency with which comment is made on the number of new physicians who come into the state each year. These observations are based usually on the gross number of physicians certified to the State Department of Health as qualified for licensure. The total number of candidates certified in the year 1947 was two hundred and sixty and if it were correct to assume that this number of physicians actually entered permanently into the practice of medicine in Connecticut, it would admittedly constitute a substantial addition to our physician population. Careful study of the records shows, however, that such is not the case. In the twelve month period covered by this report, there were issued two hundred and three licenses to practice. The breakdown of this figure yields further information of significance. The two hundred and three licenses were issued to:

House officers in hospitals	46
Staff members in State institutions	14
Staff members, Veterans Administration	5
Total	65

The number of physicians presumably intending to engage in private practice, then, is reduced to 138. The membership records of the State Society provide data on losses in the physician population during the year among members only:

Lost by death	36
Lost by transfer to other states	12
Total	48

The net gain for the year, therefore, including nineteen physicians in full time institutional positions, is 109 physicians and this increment, far from leading to an over-supply, may not even be adequate.

A far reaching court decision favorable to the Medical Examining Board was rendered by Judge King in the Superior Court for Hartford County on December 8, 1947. (Number 76770, *Jaffe* v. *State Department of Health.*) The decision established that the members of the Boar being physicians, were entitled to reach their own decisio as to the quality of medical care rendered and need n rely in addition on the testimony of medical expert wi nesses. The decision was published in the Connecticu State Medical Journal, March, 1947, page 251.

REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Edmund L. Douglass, *Chairman*

Charles H. Sprague — Charles T. Flynn
Benjamin B. Robbins (deceased) — Leonard W. Levine
W. Bradford Walker — Brae Rafferty
Richard F. Grant

Due to the fact that no legislative matters were brough to the attention of the committee during the year, ther were no meetings.

Respectfully submitted,
Edmund L. Douglass

REPORT OF THE COMMITTEE ON NATIONA LEGISLATION

Oliver L. Stringfield, *Chairman*

Benedict R. Harris — Ralph M. Tovell

The members of your National Legislation Committe have been regularly informed relative to national legislatio bearing on medicine. According to the best informatio available, there is little likelihood that action will be take in this Congress on the President's National Health Pro gram.

S. 1290, the National School Health Act, calls for com plete diagnostic and therapeutic care of all school children regardless of race, creed, color or social status. This bil is sponsored by Senator Saltonstall and others, including Senator Baldwin. The following telegram, expressing th stand of officers of the State Society and County Medica Associations was sent to Senator Baldwin:

"The Council of the Connecticut State Medical Society and the Presidents and Secretaries of the component county medical associations in a conference March 1 voted unanimously to request you to reconsider your support of parts of S. 1290 providing curative medicine fo school children whose parents are able to pay for it. Attention is directed to statement of Dr. James R. Miller before Senate Health Sub-committee March 9, copy in mail."

No meeting of the committee as a whole has been held since the last report.

Respectfully submitted,
Oliver L. Stringfield

REPORT OF THE COMMITTEE ON HOSPITALS

Robert R. Nesbit, *Chairman*

William H. Curley — Albert W. Snoke
James C. Fox — Harold W. Wellington
Louis P. Hastings

The committee has held no meetings during the year.

Respectfully submitted,
Robert R. Nesbit

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

C. Frederick Yeager, *Chairman*

Preston N. Barton
Harold A. Bergendahl
Ronald F. Buchan
Bernard S. Dignam
John N. Gallivan
Albert S. Gray
Martin I. Hall
Reinhold F. Hertzberg
Richard J. Hinchey
Andrew J. Jackson
John F. Kilgus
Robert P. Knapp
Arthur B. Landry
Eugene F. Meschter
Philip J. Moorad
Frank T. Oberg
Israel S. Otis
Crit Pharris
Arthur A. Tower
Paul W. Vestal
Ellwood C. Weise

The following report of the Committee on Industrial Health of the Connecticut State Medical Society covers the activities of this committee since the last annual meeting of the House of Delegates.

There were five general committee meetings during the year with an average membership attendance of over 70 per cent. The activities of the sub-committee, however, have been continuous and extensive throughout the past year.

Dr. Williard F. Machle, Industrial Medical Consultant, was procured to speak to the Section on Industrial Health of the Connecticut State Medical Society at its 155th Annual Meeting April 29, 1947 at the Hamden High School. Dr. Machle spoke on "Industrial Noise As It Affects The Ear." He discussed the effect of industrial noise upon the hearing of employes, evaluation of pre-employment hearing acuity, hearing losses in military service—their prevalence and severity, and methods of acoustic protection and their value in industrial processes. The Sectional Meeting was well attended by both industrial physicians and otolaryngologists. Dr. Machle's paper was subsequently published in the December 1947 issue of the Connecticut State Medical Journal.

The Cheney Brothers Manufacturers in Manchester, Connecticut, together with Dr. Robert P. Knapp, Medical Director of Cheney Brothers, served as hosts to this Committee, May 28, 1947. Preliminary to the meeting the members were escorted thru the entire plant on an inspection tour. The tour covered every process in the manufacture of silk and rayon fabrics beginning with the drawing board to the finished product. Discussions were held incident to the accident and health hazards in the plant and the methods used to safeguard the employe's health. The inspection tour included a trip to the parachute testing field. The test demonstrations simulated all possible flying conditions encountered by a dropping parachute.

Following a very delightful dinner, Mr. Henry R. Mallory, Executive Vice-President of Cheney Brothers, spoke on the influence and value their medical department had on the employes of their company from the standpoint of economy and human salvation. The industrial medical program of this company was inaugurated in 1915 and it is one of the oldest in the country. Their facilities for protecting the health and welfare of the workers were found to be excellent. The trip to Cheney Brothers was extremely valuable; all members had broadened their knowledge of industrial medicine.

Thirteen members, out of a total membership of 22, of this Committee received Certificates from the Yale Institute of Occupational Medicine and Hygiene at the School of Medicine, Yale University, after completing the Postgraduate Course on Industrial Medicine in 1947. Dr. Ronald F. Buchan is the Clinical Director of the Institute and also a member of this Committee. Many of the members are repeating this course which began February 4, 1948. This course is becoming increasingly popular and the fourth year medical students rate it the highest from the student interest point of view. It is contemplated that the undergraduate and postgraduate education on this subject will continue to expand proportionately to the interest of the students and physicians and the demands of industry.

Certain members of this Committee were invited to participate in a joint meeting with the special committee appointed to study the Workmen's Compensation Act of Connecticut. After considerable discussion it was the opinion of many present that the Compensation Laws in Connecticut at present are adequate.

The Industrial Health Committee was well represented at the 32nd Annual Meeting of the American Association of Industrial Physicians and Surgeons, April 26 to May 4, 1947 at Buffalo, New York, and the Eighth Annual Congress on Industrial Health of the American Medical Association in January, 1948 in Cleveland, Ohio.

The sub-committee on industrial nursing has been quite active during the past year, working together with the Industrial Nurses Committee of the Connecticut State Nurses Association. The Committee has endorsed a brochure prepared by the Industrial Nurses' Committee containing Standing Orders for Nurses in Industry for Connecticut. The Committee has also assisted physicians in Massachusetts in endorsing similar brochures for industrial nurses.

The Committee was the guest of the Pratt Whitney Division of the United Aircraft Corporation, November 19, 1947, in East Hartford. A total of 30 physicians attended this meeting, some of whom were consultants to the industry. The total attendance was 43, which included safety inspectors, industrial nurses and insurance personnel. The tour was precisely timed and managed. The innumerable intricate manufacturing processes and their related health hazards were observed and discussed. The tour included a most interesting lecture and demonstration of the principles of jet propulsion. Following the tour the group was escorted to the Safety Department and the Main Plant Hospital. These departments were found to be totally complete with personnel and equipment to carry out every requirement of industrial medical practice.

Following a very enjoyable dinner Mr. J. L. Bunce, Factory Manager, spoke on the subject of Human Relationship and Technicological Problems in industry and how they are mutually dependent upon good Industrial Medicine. Mr. M. F. Burke, Personnel Director, spoke on the value of the prevention of occupational injuries and disease.

This in-plant type of meeting has proved to be invaluable to the members of the Committee and we are deeply indebted to our hosts.

The Industrial Health Committee served as one of the participating agencies at the Third Annual Conference of

the Connecticut Safety Society held in Bridgeport, March 3, 1948 at the Hotel Barnum. This Conference attracted Safety Engineers, Industrial Physicians, Industrial Nurses, Personnel Directors and Plant Executives from industries throughout the entire State of Connecticut.

This Committee has undertaken the responsibility for arranging the entire Program of the Spring Meeting of the New England Conference of Industrial Physicians and Surgeons, (local affiliate of the A. A. of I. P. & S.), to be held at the Bond Hotel, Hartford, Thursday, May 27, 1948. The entire program will appear in the CONNECTICUT STATE MEDICAL JOURNAL and all members of the State Society are invited to attend any or all sessions.

The combined efforts of all the members of this Committee, their interest and enthusiasms have been beyond any expectations and I am sincerely grateful. The Committee pledges itself to increase its efforts to safeguard the health of employes.

Respectfully submitted,
C. F. Yeager

REPORT OF THE COMMITTEE ON PREPAID MEDICAL SERVICE

James R. Miller, *Chairman*

Cole B. Gibson	Thomas P. Murdock
Joseph H. Howard	Herbert Thoms

After the Society's Committee on Prepaid Medical Service presented its report at the interim meeting of the House of Delegates on December 4, 1947, it was voted that the report be submitted to each member of the Society and that the county associations be instructed to hold special meetings as soon as possible for the purpose of discussing the report and that after these county meetings had been held, the House of Delegates be called together again for a special meeting. All of this has been accomplished and the House of Delegates met in a special session in Hartford on January 28, 1948 for the sole purpose of discussing the report on Prepaid Medical Service and the action taken by the county associations in their special meetings. That meeting finally concluded with the passage of a motion to "refer the matter back to the Committee for further improvement" and although it was not included in the motion that a new report be prepared by the Committee to be submitted to the county associations at their annual meetings in April 1948 and to be considered by the House of Delegates at its annual meeting on April 27, 1948, the Committee infers that such was the intent.

The Committee on Prepaid Medical Service has proceeded as directed by the House of Delegates. It has held several conferences within itself and a large conference in New Haven on February 26 which was attended by more than fifty physicians selected by the hospitals in Connecticut and the specialty sections of the Society. Representatives of Connecticut insurance companies interested in the question were also present.

As a result of this progress, the Committee now wishes to submit a report. Certain basic objections to the proposals made in the Committee's report of December 4 have been encountered, they are:

A. SERVICE CONTRACT

There appears to be a general objection to the inclusio of a service feature in the Society's medical service pla

B. COMMERCIAL INSURANCE CARRIERS

There has been objection to the proposal that this insu ance be carried on a competitive basis by old line insuranc carriers and frequently, proposals have been made to hav the business done by non-profit sharing corporations.

C. INDEMNITY SCHEDULES

The indemnity schedule proposed by the Committee ha received a good deal of criticism, particularly from group in special fields who feel that the payments suggested fo their services are low. This has been a common experienc in other states engaged in the development of prepaid med ical service insurance. Beyond this, however, there seem to be wide agreement that the level of indemnity should b increased and this idea is held even though it is realize that to increase all of the indemnities to a higher level wil involve a proportionate increase in the premium to b charged.

D. INDEMNITY PLAN

It is the Committee's impression that members of th Society are in fair agreement that an indemnity plan fo prepaid medical service would be desirable although ther are objections to it also.

The sole desire and purpose of the Committee is t answer the question of prepaid medical service insuranc for Connecticut in a way that will be most satisfactory t a majority of the members of the Connecticut State Medica Society. If the answer to that question is to abandon th proposal entirely, the Committee is ready to do it, ever though it will do so reluctantly, because it is the belief o the Committee that the position of the medical professio in the state will be enhanced if it takes leadership in makin a useful plan of prepaid medical insurance available to th people.

The Committee has been impressed by the debate an proposals it has heard in the several county association meet ings and in the House of Delegates and in the light of thi knowledge it now proposes:

(a) That the Society give its approval and encourag the distribution of prepaid medical service insurance con tracts meeting certain standards by old line insurance car riers and any non-profit medical insurance corporation or ganized and operated under Chapter 192c Cumulative Stat utes of Connecticut.

(b) That the contracts to receive approval by the Med ical Society shall include:

1. An indemnity schedule with a $225.00 maximum and indemnities for specific services ranged appropriately within the maximum.

2. The coverage shall include surgical and obstetrical services inside and outside of hospitals and services of physicians on a fee per visit basis for medical (non-surgical) cases when patients are in hospitals only.

3. Indemnity for surgical assistants when required at major operations.

4. Indemnity for administering anesthesia when given by licensed physician.

5. Indemnity for reasonable and required bedside consultation.

(c) That a service feature be a concomitant of the contracts through voluntary agreement on the part of members the Connecticut State Medical Society, but that this rvice feature shall not be a stipulation in the contract. he service feature will operate by voluntary agreement to e effect that the sums mentioned in the indemnity sched- e will be accepted as full payment for service rendered single persons whose income does not exceed $1800.00 r annum and married persons and their minor dependents ose family income does not exceed $2500.00 per annum. he service agreement which members of the Society will asked to participate in shall also provide a means for nsideration and arbitration when a subscriber in the family oup whose income falls between $2500.00 and $3500.00 r annum feels that he has a just complaint of overcharge the part of the attending physician.

As an alternative, if the members of the Society are willing to accept a plan containing service features, the mmittee believes that the proposals made above with the mination of item (c) will meet that purpose. The Com- ttee wishes to comment upon certain proposals made at various conferences.

REEMENT UNDER SERVICE FEATURE

Without an agreement on the part of physicians, a serv- e feature is nullified. Unless there is this assurance under service contract, it cannot be recognized is a service ntract.

EDICAL SERVICES

It is the Committee's belief that provision for useful edical service should be included in the original contract possible and perhaps such medical service coverage should optional with the subscriber for an additional premium.

NESTHESIA

The proposal that payment for anesthesia be made on a ding scale for the time involved docs not appear prac- al to the Committee although it is largely accepted as method of payment in non insured cases. The proposal at the payment for anesthesia be limited to those cases hen the anesthesia is given by a certified or otherwise cognized anesthestist is also impractical of application. the opinion of the Committee, it is no more justified to quire the services of a certified anesthetist than a certified rgeon or obstetrician.

CHEDULE OF INDEMNITIES

With the recommendation of an increase of the maximum demnity from $150 to $225 (Page 2, (b) 1) the Com- ittee proposes to revise the schedule of indemnities in- luded in its report of December 4 by a general increase f 50 per cent. In addition to this overall upward revision, he indemnities for certain services will be reappraised in he light of advice and suggestions received from several embers of the Society, and will include time limitations r care on a service basis and conditions (orthopedic and thers) where treatment may be prolonged.

CONCLUSION

In concluding this report, the Committee wishes to suggest respectfully that the county associations prepare the House of Delegates to arrive at some conclusions at the annual meeting to be held in Bridgeport on April 27. To this end, it is proposed that the councilors, presidents, and secretaries take this report back to the annual meeting of their county associations where free discussion of the subject can again be entered into on the local level and without the official presence of a member of the Society's Committee on Prepaid Medical Service.

In the opinion of the Committee, the House of Delegates should be prepared to arrive at some of the following conclusions:

(a) To approve a prepaid medical service plan including *service* and *indemnity* features, the service feature to apply to insured persons who are single and whose annual income does not exceed $1800 a year and to insured persons who are married and their minor dependents whose family income does not exceed $2500 a year. (Other income levels may be found desirable.) To encourage the sale of such contracts approved by the Society by commercial insurance carriers and non profit sharing corporations.

(b) To approve a prepaid medical service insurance plan on an indemnity basis without service agreement and to encourage the sale of such contracts approved by the Society by commercial insurance carriers and non profit sharing corporations.

(c) To abandon the prepaid medical service insurance project and discharge the Committee.

Respectfully submitted,
James R. Miller

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Maurice J. Strauss, *Chairman*

John W. Buckley	L. Rogers Morse
Donald A. Bristoll	Luther K. Musselman
Howard S. Colwell	Karl T. Phillips
Clair B. Crampton	J. Harold Root
Gilbert R. Hubert	Oliver L. Stringfield
Alfred Labensky	Alfred B. Sundquist
Joseph I. Linde	Carl L. Thenebe
William H. McMahon	F. Lee Mickle, *Associate Member*

Mr. President and Members of the House of Delegates:

Gentlemen:

The Public Health Committee has again this year followed the policy of previous years of being available for advice and assistance to the Connecticut State Department of Health and in that manner acting as a liason between the Connecticut State Medical Society and the State Department of Health.

Three meetings have been held with an average attendance of 14. Only one member of the committee has found it impossible to attend any of the meetings.

The State Department of Health asked the advice of the committee on the question of establishing further demon-

stration areas in maternal and child health. The proposed program was recommended after making some changes.

The State Department of Health asked the advice of the committee on the question of triple combined immunization. The committee recommended that the State Department of Health have available such an immunizing agent, both alum precipitated and fluid, and be prepared to furnish it to the physicians of the state.

A great deal of time and thought has been given to a study of proposed revisions in the "Suggested Standing Orders and Policies for Public Health Nurses." This is considered to be an important matter because this provides a working code whereby the Public Health Nurses may be of great assistance to the physicians of the state. The proposed changes were discussed again and again and finally at a meeting of the committee on January 29, 1948, the revised pamphlet was acepted as a whole. The Commissioner of Health approved of these changes.

The question of the advisability of substituting penicillin for silver nitrate in the prophylaxis of ophthalmia neonatorum was brought before the committee. The committee felt that the supposed advantages of Penicillin had not yet been demonstrated clearly enough to outweigh the possible disadvantages of its use for this purpose, and that since silver nitrate had proven to be a successful and harmless drug for this purpose, its distribution by the State Department of Health be continued.

In an attempt to bring the various subcommittees of the Public Health Committee more closely into the orbit of the main committee a meeting was held at which the chairman of the various subcommittees were invited to present reports of their committees' activities. At this meeting it was brought out clearly that there are some great discrepancies between fees paid to physicians who do part time work for the State Department of Health. The Public Health Committee has gone on record as recognizing the importance of the study of this problem being carried out by a committee of physicians appointed for this purpose by the State Department of Finance and Control.

At this same meeting the Chairman of the Subcommittee on Hearing presented definite proposals for a program to combat the growing problem of hearing loss. This program is now under discussion between the Chairman of the Subcommittee on Hearing as a representative of the Public Health Committee and the Commissioner of Health in a attempt to formulate the most practical and workable program possible and prepare plans for its implementation.

It is of importance to note that the list of reportable diseases in the Connecticut Sanitary Code has been completely revised. Through some error this list in its final form, was not submitted to the Public Health Committee before it was sent to the printer. However, at the last meeting the list was presented to the committee and none of the members present had any objections to the list.

The chairman wishes to express his appreciation of the interest shown by the members of the main committee and of the subcommittees as well.

Respectfully submitted,
Maurice J. Strauss

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

C. Charles Burlingame, *Chairman*

Edwin R. Connors	Brae Rafferty
Thomas J. Danaher	Maurice J. Strauss
George Gildersleeve	C. Frederick Yeager
Averill A. Liebow	Howard W. Haggard, *Associate Memb*

During the past year three new services have been deve oped by the public relations section of the Society. The comprise a weekly radio program, an information servi for physicians, and a health column for weekly newspape

The radio program, "Doctor's Orders," was inaugurat last October, following approval by the Committee Public Relations and the Society's Council. The series broadcast every Sunday at 1:15 P. M., over the stations the Yankee Network, WONS in Hartford; WICC Bridgeport; WWCO in Waterbury; and WNLC in Ne London. Other medical organizations which are sponsori "Doctor's Orders" include the Rhode Island State Medic Society, the Massachusetts State Medical Society, and t New York State Medical Society.

The new "Physicians' Information Service" has on recently been started. Its purpose is to provide membe of the Society with current information concerning ec nomic developments which affect the practice of medicir The material selected for this service includes valuable a carefully prepared studies of medical economics by respo sible agencies. Mailing of these publications to all membe of the Society would constitute too large an expenditu and the mailings are therefore directed to hospital readi rooms throughout the state at thirty-day intervals. Ea publication bears the name of the Society, and invit physicians who desire personal copies to communicate wi the public relations section.

"Your Health," the column for weekly newspapers, fi appeared in Connecticut's community publications on D cember 19 of last year. Each column bears a distincti heading and the name of the Society. Material for the columns is edited or prepared by a sub-committee of t Society's Committee on Public Health, under the chairma ship of Dr. Joseph I. Linde.

Including the new projects described above, the Societ major public relations activities can be outlined as follow

1. Press releases for daily and weekly newspapers.
2. Articles and release for: CONNECTICUT STATE MEDIC JOURNAL, *Journal of the AMA, Connecticut Pharmaci* other publications from time to time.
3. Radio program "Doctor's Orders."
4. Weekly newspaper column "Your Health."
5. Editorial Information Service.
6. Physicians' Information Service.
7. Speaker's Bureau.
8. Services to committees: Committte on Industrial Healt Committee on Medical Care of Veterans, Committee Public Health, Committee on Public Relations, Committ on Pharmacy and Medicine.
9. Industrial-health conferences with management.

10. Cooperative endeavors with other organizations: Vet-ans Administration, Connecticut Rehabilitation Association, onnecticut Pharmaceutical Association, Connecticut Can-r Society, Connecticut Dental Association, Connecticut onference of Social Work, Connecticut State Federation Women's Clubs, Connecticut Manufacturers Association, onnecticut Society for Crippled Children and Adults, onnecticut Tuberclulosis Association, Connecticut Veter-is Advisory Commission.

It should be noted that these services are aimed at groups well as the public at large. Groups furnish a valuable enue of approach because people are generally more ceptive to information when it has some bearing upon eir group interests. These interests may be occupational, cial, political, or recreational, with many sub-divisions in tween. They are often important motivating factors, and is concept has played a useful part in the selection of blic relations devices.

Another consideration in developing the present program as been to refrain from the use of devices which call ndue attention to technique. The objective is to produce rvices which honestly assist individuals in those groups hich should actively support the ideals of medicine.

Respectfully submitted,
C. Charles Burlingame

REPORT OF THE COMMITTEE ON TUMOR STUDY

Averill A. Liebow, *Chairman*

Robert R. Agnew	Kenneth K. Kinney
Irving B. Akerson	Gustaf E. Lindskog
John D. Booth	Christie E. McLeod
Donald A. Bristoll	Philip G. McLellan
Willard E. Buckley	William Mendelsohn
Gerard M. Chartier	Lincoln Opper
Harold M. Clarke	Edward J. Ottenheimer
Joseph O. Collins	Berkley M. Parmelee
A. Nowell Creadick	Karl T. Phillips
Thomas J. Danaher	Douglas J. Roberts
Edward W. Foster	Allan J. Ryan
Carl C. Harvey	Louis G. Simon
Louis P. Hastings	E. Myles Standish
Joseph H. Howard	Herbert Thoms
Rolf E. Katzenstein	Frank Turchik
Russell A. Keddy	Donald B. Wells
Ralph E. Kendall	State Commissioner of Health

The Tumor Committee as a whole met four times and oncerned itself chiefly with the following problems. 1. A eytological diagnostic program. 2. The preparation of statistical information concerning cancer in Connecticut. 3. Reorganization of the Committee.

Chairmen of sub-committees, who function as the Executive Committee were appointed as follows: Scientific, Dr. Kendall; Medical Education, Dr. Ottenheimer; Institutional Care, Dr. McLellan; Public Relations, Dr. Roberts; Publications, Dr. Thoms; Secretary, Dr. L. P. Hastings. This group functioned faithfully and well and met many times in addition to the scheduled meetings of the entire Committee.

A plan for establishing cytological training and diagnostic centers at the Tumor Clinics of the New Haven and Hartford Hospitals was submitted for consideration by the Connecticut State Association of Pathologists. This plan was approved and referred to the chairmen of the tumor clinics concerned and to the Medical Advisory Committee of the Connecticut State Cancer Society. The problem, in essence, is the adequate training of physicians and technicians in an exacting task. It is obvious that practially all the screening of smears will have to be performed by the latter, if the procedure is to be carried out on a large scale, but that physicians must themselves be well trained to be competent to supervise. The establishment of the two centers initially seems wise, since experienced personnel is already available there to conduct the training of others. The major purpose of the centers is to provide competent technicians for hospitals throughout the state. Pathologists desirous of acquiring experience in the technique will likewise have available large quantities of instructive material at the two centers.

The Committee has deemed the presentation of data concerning the incidence of, and mortality from, cancer in Connecticut a project of major importance. The body of statistical information that has been accumulating since 1935 in the Tumor Record Registry of the Division of Cancer of the Connectiut State Department of Health is unique in that it is representative of a large heterogeneous population. The statistics of any single hospital tend to be too much colored by selective factors. The Cancer Division has flourished for more than twelve years under Dr. Matthew Griswold, Chief. The devoted efforts of Miss Eleanor MacDonald, Research Statistician, have contributed tremendously to the value of the Registry. The Committee considered that the analysis of the Tumor Registry Records should be carried out in part by the physicians who supplied the records. In this work two major phases were contemplated:

1. The first phase represents a general statistical presentation of malignant disease in Connecticut. With the aid of the Cancer Division, which supplied the basic tables, the Committee has prepared a general survey covering the incidence of the major types of cancer, in relation to sex and age, and whether or not histological proof was available. This will be published in a forthcoming issue of the Connecticut State Medical Journal.

2. The second phase involves the detailed clinical analysis of the records for the purpose of assessing diagnostic methods and the effects of treatment, as well as for determining facts of the natural history of the disease. This phase is in process of organization. Teams to cover the major varieties of malignant disease are being formed and a coordinator of the project will be selected for liaison between the teams and the Cancer Division, and to assure uniformity of presentation. Nominations for the team and for the coordinator have been requested from the association of Tumor Clinics. The obvious desirability of ultimately collecting this information in monographic form has been emphasized by the Committee. Such a monograph will provide a base line by which trends in incidence as effected by diagnostic methods, treatment, and other factors may be measured, in Connecticut as well as throughout the country.

The problem of reorganization of the Tumor Committee was considered at the request of the officers of the State Medical Society. It was the recommendation of the Committee that its membership be maintained in as representative a form as at present, and that the following be included in the membership: President of the Connecticut Cancer Society; Chairman of the Association of Tumor Clinics; and Chief of the Division of Cancer of the Connecticut State Health Department.

Nominations to the Medical Advisory Committee of the Connecticut Cancer Society were made, and subsequently voted into office by the Society, as follows:

Dr. Alfred L. Burgdorf, Hartford, *Chairman*
Dr. Wilmar M. Allen, Hartford
Dr. Howard S. Colwell, New Haven
Dr. William U. Gardner, New Haven
Dr. Joseph I. Linde, New Haven
Dr. Edward J. Ottenheimer, Willimantic
Dr. Donald B. Wells, Hartford

Most of these were reappointments made in recognition of their very notable contributions to the cause of the Society. The repeated requests of Dr. George M. Smith to be relieved of his responsibilities were honored with deep regret. It was voted that at least two members be rotated in subsequent nominations. This Committee is deserving of the highest praise for its work.

The reports of the Medical Advisory Committee and of the Association of Tumor Clinics follow. The planning and activation of an expanded consultative program for the Clinics by the latter is a notable step forward.

REPORT OF THE ASSOCIATION OF TUMOR CLINICS

The Association of Tumor Clinics has continued its activities in endeavoring to improve the level of diagnosis and treatment of cancer throughout the state. On November 13, 1947, the fall meeting of the Association was held at New Haven Hospital and a program devoted largely to developments in the investigative phases of cancer was presented by members of the faculty of the Yale University School of Medicine. This proved to be a stimulating meeting and was well attended by representatives from most of the clinics in the State.

Dr. William Wawro has continued as Executive Secretary and his stimulating interest in the cancer program has contributed largely to the success of the activities of the Association. As a result, many clinics have expressed the desire for a consultant in regular attendance at their Tumor Clinic meetings. This should prove an effective way of raising the level of cancer diagnosis and treatment.

Accordingly, a special meeting of the Association was held on December 17, 1947, to discuss such plans. It was the unanimous opinion of those present that such a consultant program be made available to all clinics desiring this service. The Executive Committee was empowered to activate this program. Each clinic has been circularized by a questionnaire as to what they wish, and at present, a panel of consultants is being prepared. Each clinic can choose the consultant they desire for this panel. It is hoped that this plan will be ready for operation in the not-too-distant future.

This program has been made possible by the generosit of the Conneciut Cancer Society.

Respectfully submitted,
Robert Tennant

REPORT OF THE MEDICAL ADVISORY COMMITTEE

The Medical Advisory Committee in addition to passin on the routine requests for funds to carry on educationa counselling, and information activities of the Society, ha concerned itself with three main problems: Allocation o funds for clinical research; allocation of funds for the oper ation of detection centers; and allocation of funds to de velop and promote a cytological program.

At the present time funds have been approved for cance detection activities in Bridgeport, New Haven, Meriden and Hartford. There is no uniformity in the programs o these four centers, and at this stage of development th Medical Advisory Committee feels that it is wise for th Society to "purchase" a variety of experience in this fiel so that whatever good appears in each program can even tually be brought together in a Connecticut Cancer Detec tion Plan.

The Medical Advisory Committee has raised the questior on several occasions as to whether state funds should flow into the research field in view of the availability of funds for that purpose from national and other sources. To date they have voted that at the present time this policy wa sound if the expenditure involved exploration of problems in the clinical field.

At present considerable thought is going into the explora tion of the cytological program. Funds have been allocated to New Haven and Hartford for this purpose, and the Committee appears anxious to promote this activity as fast and as far as possible.

A copy of the grants as approved by the Medical Advisory Committee is attached.

GRANT ALLOCATIONS—SEPTEMBER 1, 1947 TO AUGUST 31, 1948
AS OF MARCH 12, 1948

Community Grants—For Information Centers, Community Secretaries, Medical Social Workers, Tumor Clinic Secretaries, etc.	$ 59,404
Detection Centers	23,345
Research, etc.	30,300
Statewide Community Services	54,215
Total (Grants appropriated to March 12, 1948)	$167,264

Alfred L. Burgdorf

Respectfully submitted,
Averill A. Liebow

REPORT OF THE COMMITTEE ON THE CLINICAL CONGRESS

Francis G. Blake, *Chairman*
Cole B. Gibson Herbert Thoms

The Twenty-Second Clinical Congress of the Connectiut State Medical Society and the Yale University School of

ledicine was held in New Haven on September 16, 17 and , 1947.

As in 1946, the program and general arrangements for ie Congress were handled by a committee from the School Medicine under the chairmanship of Dr. Arthur J. eiger. Publicity and registration were managed by the ffice of the Executive Secretary.

The plan of the Congress consisted of morning lectures the Law School, luncheon meetings at the New Haven lospital and afternoon symposia and panel discussions at ie Hospital and the School of Medicine.

The enrollment was somewhat lower than usual, with ist over five hundred persons registered.

The Clinical Congress Committee wishes to take this pportunity to express its deep appreciation of the splendid ork of the Committee on Program and Arrangements.

Respectfully submitted,
Francis G. Blake

EPORT OF THE BOARD OF TRUSTEES OF THE BUILDING FUND

James D. Gold, *Chairman*

Stuart H. Bowman
C. Charles Burlingame
Edmund L. Douglass
Cole B. Gibson
Michael E. Giobbe
Donald J. McCrann
Ralph W. Nichols
Edward J. Ottenheimer
George M. Smith

Our February report to the Council requested their pproval of the following procedure: that the building com- ittee consult with the architect stating our desire to build, ie entire cost of the project not to exceed $75,000.

Secondly: a request that the State Socitey subsidize the uilding fund to the amount of $15,000. This money ould be returned to the Society as contributions were eceived. Solicitations will be continued and it is expected he response will be stimulated by the visual activity of a uilding under construction.

The number of non contributors is 52 per cent.

Memorial Fund additions are as follows: $3,250. Dr. David Chester Brown of Danbury. This was secured from he many friends of Dr. Brown thru the efforts of Dr. Samuel Mullins, Dr. John Booth and Dr. William Stahl.

A check from Mrs. Austin Cheney for $300 has been eeeived in memory of her husband, Dr. Austin Cheney of New Haven.

Although the funds are not up to our expectations it eemed necessary to start building now as the needs of the tate office call for immediate expansion to accommodate the ersonnel. The proposed building will be so constructed hat it may be added to as need for so doing arises. This uilding may not be what you or I have visualized yet it will be adequate for our needs.

Respectfully submitted,
James D. Gold, *Chairman*

REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

Thomas P. Murdock, *Chairman*

Creighton Barker
Edmund L. Douglass
James R. Miller
Herbert Thoms

Mr. President and Gentlemen of the House of Delegates:

The Committee on Cooperation with the Yale School of Medicine has held three meetings since the midwinter meeting of the House of Delegates.

Progress is being made with the diagnostic clinic. The staff is being organized under the direction of Dr. H. L. Dwyer. It is believed by all concerned that this will be a great addition to medicine in Connecticut. Only patients referred by doctors will be accepted.

The plans for postgraduate education are now well underway. Dr. W. R. Willard is in charge of this activity. The committee feels that this is a great step forward. The prime reason for the existence of the Connecticut State Medical Society is to elevate the standards of medical practice and to provide postgraduate education for its members. Much is to be expected from this development.

The committee is studying various means and methods of providing federal aid for medical schools. It is very probable that the congress will make some provision at this or the next session. The representative from Yale Medical School, if asked, will bring to the Congressional Committee the opinion decided by this combined committee.

The representatives of the school and your committee are happy to report that very cordial relations exist between the State Society and the authorities of the medical school. This is as it should be. Meetings will be continued and attempts will be made to solve problems as they are presented.

Respectfully submitted,
Thomas P. Murdock

REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, *Chairman*

Egbert M. Andrews
Norton Canfield
Joseph N. D'Esopo

The Home-Town Medical Care Plan for Connecticut Veterans has continued to expand since the last annual report of this committee. As of March 20, the total number of physicians enrolled in the plan numbered 1,148. Enrollments in our eight counties were as follows: New Haven County—359; Hartford County—328; Fairfield County—284; New London County—63; Litchfield County—54; Middlesex County—29; Windham County—22; and Tolland County—9.

One of the chief activities of the committee has been to prepare fee tables for surgical procedures, in response to a request by the Veterans Administration. These were recently completed and submitted to the administration for approval.

In constructing these new tables the committee has made every effort to see that the fees recommended coincide with normal fees in the several sections of the state. Sample fee

tables were mailed to the eight county medical associations, acompanied by letters requesting that the committee be informed concerning local fees for the procedures listed. The committee was disappointed in the response to this request. Only four of the county associations submitted recommendations, and the committee was therefore forced to conclude that those which did not respond had no recommendations to offer.

In this connection it is pertinent to emphasize that the problem of veterans' medical care is one which is not only permanent, but which will continue to expand as the veteran population ages. Also, this population continues to mount in number as war veterans who remained in the service return to civilian life. The popular conception of a veteran population of 15,000,000 in this country is no longer valid. This figure has now increased to more than 18,500,000.

It is possible that the future may bring the further extension of medical service to veterans with non service connected disabilities, and perhaps some type of medical service for their dependents.

These are some of the considerations which the committee has tried to keep in mind when initiating action, and they have taken particularly important in connection with fee table preparation.

During the past year a problem arose concerning the establishment of a separate board of review to hear grievances, but it was finally determined that the present committee already has this authority. However, no grievances have been brought before the committee since inauguration of the Home Town Medical Care Plan in the fall of 1946.

The committee has requested officials of the Veterans Administration to conduct a center on Veterans Medical Care at the 156th annual meeting of the Society, in Fairfield. This request has been granted and the necessary arrangements have been made. Completely new forms for the use of fee designate physicians will be placed in use about May 1 and these will be explained at the center. Members of the Society are invited to avail themselves of this opportunity to discuss matters pertaining to the medical care of veterans.

Respectfully submitted,
Samuel B. Rentsch

REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

Norman H. Gardner, *Chairman*

David H. Bates	Gaert S. Gudernatch
James F. Ferguson	William H. Upson

The Committee on Rural Medical Service is still planning to have some type of conference this year, although the form this will take is still undecided. At first it was planned to hold a small regional conference in one of the more rural parts of the state, but there is now some chance that we may be able to have a part of a day devoted to rural health problems during the Farm Week End at the University of Connecticut. This would be an ideal situation for our purpose.

The chairman of the committee represented the Connecticut State Medical Society at the Annual Conference on Rural Health in Chicago on February 6 and 7 of this year. The conference was better attended than ever before and the spirit of cooperation was everywhere apparent. No one can doubt that the farm groups are becoming more and more confident in our sincerity to help them. The conference conerned itself in the main with rural youth. One of the high spots was the panel discussion by four young people representing the various farm groups. Anyone who attends one of these conferences will realize how very important our work with the rural groups is becoming. We are getting better and better acquainted with one of the most influential groups in the country.

The formation of local health councils is to be the special effort of the National Committee on Rural Medical Service this coming year. Several states now have health council on the state level, and these are working very well, but it is felt that a local health council will do much for the small towns in helping them to formulate some specific program for improvement in local health. This would put the general formation of health policies where it should be—in each local area. In many ways such a local council could be considered to be a town improvement committee instead of only a health council, for there are so many things which either directly or indirectly influence health. This refers to better roads, better schools, better playgrounds as well as better health supervision.

Respectfully submitted,
Norman H. Gardner

REPORT OF THE COMMITTEE ON DRUG ADDICTION

John H. Foster, *Chairman*

E. T. Brennan	Edgar C. Yerbury
Arthur H. Jackson	Howard W. Haggard,
Alfred Labensky	Associate Member

The drug addiction problem seems to be very well under control in Connecticut, but this is only because we have laws which have been drawn up for our protection plus the unremitting efforts of narcotic agents of the Bureau of Preventable Diseases in our State Department of Health. The number of drug addiction cases handled by the Department of Health for the past three years are as follows:

Year	*New*	*Old*	*Total*
1945	39	33	72
1946	27	47	74
1947	55	45	100

This is almost double the number handled ten years ago. The effect of post war overseas smuggling is already being felt in this state and some mariahuana has recently been picked up by our agents.

Aside from the actual problem of running down and apprehending the addicts the biggest problem of our narcotic agents is enforcement of the federal and state narcotic laws regarding the prescribing of narcotics by physicians. The law provides that narcotics shall be prescribed only in writing with ink or indelible pencil or typwritten, giving full name and address of patient and signed with the legal signature of the physician.

A letter is to be sent to each physician from the State epartment of Health with a copy of the narcotic laws d explanations. The law forbids pharmacists to fill tele-hone orders for narcotics. The only provision for an hergency is that a druggist may deliver narcotics if the escription is supplied to him before the delivery of the ug is made. We all know that the druggists in acom-odating physicians are often compelled to break this law. hey are the ones who suffer for failure to comply with e provisions of the law. The State Department of Health going to enforce the law throughout the state. Should ey fail to do this we may have the Federal Bureau of arcotics stepping in as they have in the past. This will ork hardships on physicians, pharmacists and patients. he drug stores are only opened certain hours and so much the doctors practice is carried on over the telephone at it does seem that some revision should be made to ovide for emergencies, yet prevent the abuse of telephone escribing.

It has been suggested that Connecticut adopt a method ed in some states for the prescribing of narcotics. This volves the State Health Department providing special arcotics prescription pads serially numbered with carbons. he prescriptions are filled out in triplicate; one copy is tained by the physician, the original and one copy go to e druggists who keep one on file and send the other to e Health Department. There are many details, but it is rather intriguing and not too complicated a scheme and being studied further.

The barbiturate problem is not entirely under control ther. Last year in Connecticut there were 4 suicides and accidental deaths from barbiturate poisoning—a total of deaths in the state. During 1945 and 1946 there were a tal of 10 suicides and 15 accidental deaths. There were er twice as many deaths from barbiturates as from all her forms of poisoning by chemical compounds, arsenic, ercury, phenol, etc.

Barbiturates are probably the most widely prescribed rugs in the practise of medicine today and appear in a undred or more combinations. They are potent drugs and ould not be prescribed indiscriminately without super-ision. There should be a check and a time limit on refills nd the present method of relying on verbal orders for efills has not been entirely satisfactory. Some revision of is law is in preparation.

The law regarding the commitment of narcotic addicts ow provides for emergency commitment for a thirty day eriod, the case then goes before a probate judge for fur-her action. It is felt that six months should be a minimum eriod of commitment for drug addicts.

The problem of alcoholism is being studied by the State Alcoholic Commission appointed by the governor. One nember of the commission is a member of this committee nd in the future we hope that this committee on Drug Addiction can be a liaison between the State Commission nd the State Medical Society; and it is hoped both will nutually benefit.

Respectfully submitted,
John H. Foster

REPORT OF THE CONFERENCE COMMITTEE WITH THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

William T. Salter, *Chairman*

Burdette J. Buck — Allan K. Poole
Barnett Greenhouse — William B. Smith

MEETINGS

Since my last report the Joint Conference Committee has had one regular meeting, which was held in New Haven on Wednesday, February 8.

COUNTY ORGANIZATION

The Conference group has suggested that a change be made in organization with respect to County representation. Inasmuch as our attempts to organize county Joint Conference Committee groups along the same lines as the State organization have not met with notable success, the Committee has endorsed the following proposal:

One representative from each of the two organizations shall be appointed from each county of the State, so that eventually all eight counties will be represented on the State Joint Conference Committee. In this manner, each County Representative might be responsible for all activities of the Joint Conference Committee relating to his particular county. It has been suggested, however, that the Joint Conference Committee be enlarged only at the discretion of the present committee, and that the new members be added only when there is a vacancy from a respective county. It has been recommended also that appointments should come through the state organizations and only at the request of the Joint Conference Committee.

CONNECTICUT COMMITTEE ON FOODS, DRUGS, COSMETICS, AND DEVICES

The above title is the semi-official designation of the proposed State Council on Pharmacy and Medicine mentioned in my previous report. The following general organizational procedure has been suggested:

1. This Committee will operate as a sub-committee of the State Joint Conference Committee.

2. The membership of the committee will be selected as follows: As an initial approach, one member from each of the following agencies:

a. The State Medical Society.
b. The State Pharmaceutical Association.
c. The State Dental Society
d. The State Veterinary Society.
e. The Connecticut State Agricultural Station.
f. The Yale Medical School.
g. The College of Pharmacy in New Haven.
h. The University of Connecticut, Storrs.

Obviously, this tentative procedure is subject to modification at the request of the parent organizations.

3. The Committee will add members on a temporary basis to supply skilled consultation for specific problems as they arise.

RECOMMENDATIONS

The Joint Conference Committee is of the opinion that steps should be taken to assure the reception of necessary

educational material concerning our mutual problems by all the members concerned. It is suggested that the parent organizations should take steps to intensify present programs dealing with the mutual interests of pharmacists and physicians.

Respectfully submitted,
William T. Salter

REPORT OF THE COMMITTEE ON STATE-WIDE BLOOD AND PLASMA BANK

Ralph E. Kendall, *Chairman*

Irving B. Akerson
Arthur J. Geiger
Averill A. Liebow
Karl T. Phillips
Donald B. Wells

During the year, several of the members have met with representatives of the Local and National Red Cross in order to develop a whole blood and plasma program in cooperation with the Red Cross at the National Level. During the year, the Association of Connecticut Hospitals, through their committee, have likewise indicated their readiness to collaborate.

The immense complexity of developing such a program can only be appreciated when one has investigated carefully the many phases that are involved. Progress, however, has been made during the year and at the most recent conference with the representatives from the National Red Cross Organization we are hopeful that an active unit will be established in the State during 1948. The invaluable experience of the Red Cross during the war and the more recent programs of varying types that have been undertaken by them in civilian work convinces your committee that great haste might lead to the establishment of an unworkable program.

The first full scale project undertaken by the National Red Cross opened in Rochester, New York, in January, 1948, and while its experience has been short, it appears to be quite sucessful and we are assured that a complete program will be presented to Connecticut in the near future.

Respectfuly submitted,
Ralph E. Kendall

REPORT OF THE COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Joseph H. Howard, *Chairman*

Eric H. Blank
Carl E. Johnson
Norman C. Margolius
Charles H. Peckham
Elizabeth C. Wells

A Committee to study maternal mortality and morbidity in the State of Connecticut was appointed a year ago. The objective was to make a detailed survey to more properly classify maternal deaths as follows:

a. To observe in reviewing histories the discrepancies which had ocurred previously between the official death certificate and the maternal mortality questionnaire.

b. To revise the maternal mortality study questionnaire. After a period of several years, the Committee recognized the fact that some changes should be made in this form, and such additions have been made.

c. To encourage more autopsies to better designate the exact cause of death. A review of maternal deaths over the past few years indicates that there are some inaccuracies and the stimulation to procure autopsies would give a more definite picture as to the cause of these deaths.

d. To propose a uniform obstetrical record for all of the hospitals in the State. This should simplify analysis of these cases, and a sub-committee is now preparing such a standard chart which has been accepted by several hospitals as an experimental project to determine its usefulness.

e. To encourage the hospitals of the State to record and classify all cases listed under morbidity standards.

During the past year seven meetings of this Committee have been held. It has been the policy to invite a physician to appear before our group to discuss the details of a maternal death. This frequently brings out information that is most valuable in properly classifying the particular case.

A review of maternal deaths indicates that there is an occasional problem by which the Committee has difficulty in classifying the cause of death. How much the factor of anesthesia enters into both maternal and fetal death is still a problem, and because of this we are now in the process of preparing a program to jointly study with the Committee on Anesthesia of the Connecticut State Medical Society the whole problem of the effect of anesthetics on the mother and the child.

The maternal mortality rate in Connecticut has declined consistently over the past several years to the point where in 1947 it had reached an all time low of 0.7 per one thousand live births. This is the lowest record of any other area in the world. Although reduction has occurred in puerperal infection and toxemia, the number of deaths from hemorrhage has been little effected. One of the major problems therefore, is to develop blood banks in all hospitals in the State. It is hoped that the Red Cross program can be worked out to the satisfaction of both the Medical Society and the Red Cross. If not, it is very probable that the American Legion may establish a system of blood distribution not only in Connecticut but throughout the country.

The meetings of this Committee have been most stimulating, and it may well be that these discussions should be open to the membership of the entire society because of their educational value.

Respectfuly submitted,
Joseph H. Howard

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Ralph L. Gilman, *Chairman*

John D. Booth
Barnett P. Freedman
James D. Gold
Frederick B. Hartman
H. Freeman Pennington
E. Myles Standish

The Committee has held no formal meeting during the year. A mail poll of the Committee unanimously approved the setting up of a *Hygeia* exhibit by the Auxiliary at any health conference held in the state. The Board of Directors voted in November to invite the members of the Advisory Committee to attend their meetings. The Chairman attended such a meeting in December and the meeting of the Auxili-

a immediately thereafter, but has not been able to attend a others.

The Auxiliary is now completing four years of organized a ivity. There are something over 800 active members, and a the counties except Tolland have county auxiliaries. They h e been gradually molding into a well organized group a l are developing a worthwhile program. They are anxi- c s to be a real Auxiliary to the State Medical Society, a eit they have minds and ideas of their own as they s uld. The fears of many of our own members that they v uld be merely another social organization may be safely l d to rest. They do have an important social function as e of their objectives, namely: to increase acquaintanceship a d better relations between the families of the physicians— a d this function has already produced tangible results.

The Auxiliary deserves the continued encouragement and s pport of the Connecticut State Medical Society both c icially and through its individual members. Its value to r Society will increase during the years ahead.

Respectfully submitted,
Ralph L. Gilman

REPORT OF THE DELEGATES TO THE COUNCIL OF NEW ENGLAND STATE MEDICAL SOCIETIES

Cole B. Gibson

Joseph H. Howard — Harold E. Speight

The Council of New England State Medical Societies ntinues to provide a valuable means for mutually profit- le intercourse between the Societies of our region. The eriodic meetings during the past year have been well at- nded by representatives from the six states.

The programs have been diverse and stimulating, and iscussions of the following have been particularly fruit- l: State Planning for Rural Medicine, by our own Dr. Norman Gardner; Group Practice in the Small Community; he Insurance Approach to the National Health Question; nti-Vivisection in New England; and the Out Patient pproach to the Treatment of Alcoholism.

A symposium on the vital subject of The New England Doctor and His Public had as discussants a radio executive, wo newspaper editors, a physician who is Director of Medical Information for a state society, a Director of Public Relations of a state society, a Professor of Public Health Practice, and a physician who is a former Governor of a New England state.

Dr. Arthur H. Ruggles, of Rhode Island, succeeded Dr. Carleton R. Metcalf as President, and Mr. John E. Farrell of Rhode Island continues as the efficient Executive Secre- ary.

It is earnestly hoped that the Council will continue to receive the support and interest of the members of the Societies, since solidarity of purpose in the New England states would be of great importance in present day matters concerning medicine in the United States.

Respectfully submitted,
Cole B. Gibson

REPORT OF COMMITTEE REPRESENTING CONNECTICUT STATE MEDICAL SOCIETY ON BOARD OF DIRECTORS OF CONNECTICUT HOSPITAL SERVICE, INC.

Arthur B. Landry, *Chairman*

Ralph T. Ogden — William C. McGuire

Whatever qualms respecting the strength of Connecticut Blue Cross may have prevailed in certain medical circles over the years 1945-6 should now be dispelled by the 1947 report of Connecticut Hospital Service, Inc.

The net membership increase in Connecticut Blue Cross in 1947 was 66,798, making the total membership of 718,470 subscribers as of December 1947. Replies from 8755 out of 28,836 subscriber patients receiving a questionnaire asking, "Did Blue Cross function to your complete satisfaction" show that 97.6 per cent answered "yes."

The huge sum of $5,804,047.42 was paid to member hospitals for the care of Blue Cross subscribers and nearly $1,000,000, was added to the reserve for contingencies. The ratio of operating gain to earnings was 13.1 per cent as compared with 0.9 per cent during 1946.

Improved though it be in fiscal standing and popularity, the strength of Connectiut Blue Cross is ever being contested by commercial insurance sold on a group basis in "one package" covering an assortment of hospital, surgical, medical, and maternity cash indemnities and disability and death benefits.

Connecticut Hospital Service, Inc., aware of this competition and public demand for additional health insurance, has given some thought to making available to its subscribers a companion prepaid medical insurance plan which may be offered to the public in the near future by Connecticut Medical Service, Inc. Presumably both hospital and medical insurance plans offered jointly would not only add strength to each organization but come nearer to meeting the subscriber need.

These voluntary insurance plans are closely related to medical practice and public health requirements. Physicians and laity alike are interested in their development. Thus these plans should be developed under the guidance of medical men and civic leaders.

Respectfully submitted,
Arthur B. Landry

REPORT OF THE COMMITTEE TO STUDY THE WORKMEN'S COMPENSATION LAWS

Thomas Soltz, *Chairman*

Ettore F. Carniglia — C. Louis Fincke
Clarence H. Cole — John F. Kilgus

There was one meeting since the last report. The meeting was held in New Haven, February 26, 1948. One member was absent.

It was decided to contact representatives of leading insurance carriers in the Workmen's Compensation field for their views of free choice.

A recommendation was made that in as much as the compensation laws were enacted for the benefit of injured workmen and since physicians are directly concerned with the problem of providing the best medical care a questionnaire be sent to both A.F.L. and C.I.O. local secretaries of each major community of the State and to the members of the Connecticut State Medical Society.

The questionnaire to be as follows:

1. Do you favor the present system of medical care in Workmen's Compensation.

2. Do you feel that medical care would improve under the principle of Freedom of Choice in the treatment of the injured under Workmen's Compensation.

3. Would you prefer the system now in existence in New York State which allows free choice of Physicians chosen and graded according to qualifications established by the County Medical Societies.

4. Poll the physicians of the State on the same questions either individually or through their county medical societies and use the same method of acquainting the members of the profession on this subject as was done in Prepaid Medical Care.

5. The majority and minority report of the Jackson Committee at the House of Delegates meeting in New Haven, December, 1946, be printed by the State Society and a copy be sent to each member of the State Society.

It was agreed to defer action on the questionnaire until after the meeting with the insurance carriers.

Respectfully submitted,
Thomas Soltz

REPORT OF THE COMMITTEE ON THE CHRONICALLY ILL

George A. Wulp, *Chairman*

Richard I. Barston — Clifford D. Moore
A. Nowell Creadick — Charles H. Sprague

In view of the newly organized Commission for the care of the Chronically Ill and Aged, working in conjunction with Commission for the Veterans at Rocky Hill, your own Committee has had no active program. It is, however, at periodic intervals, meeting with the Commission of the Chronically Ill, and is acting in an advisory capacity there. In view of the importance of the problem of the care of the Chronically Ill, your Committee feels that any help which the Physicians of Connecticut can give to the Commission in determining the number of Chronically Ill and where they are, would be very beneficial.

The use of the Hospital facilities at the Connecticut State Veterans Home and Hospital in Rocky Hill will be of great help from the standpoint of both care and study of chronic disease and your Committee hopes to keep in constant touch with progress being made there.

Respectfully submitted,
George A. Wulp

REPORT OF THE LIAISON COMMITTEE TO THE INSTITUTE OF OCCUPATIONAL MEDICINE AND HYGIENE

Thomas P. Murdock, *Chairman*

Creighton Barker — C. Frederick Yeager

Mr. President and Gentlemen of the House of Delegates:

The Liaison Committee to the Institute of Occupation Medicine and Hygience has held two meetings with th director, Dr. R. F. Buchan.

At these meetings basic plans were made for a post gradu ate course in industrial medicine and surgery this year. Th details were worked out by Dr. Buchan and his associate

The course opened on February 3, 1948 and conclude on April 6, 1948. Weekly sessions were held. The prograr was an excellent one. The subjects covered were we selected and the speakers outstanding leaders in Industria Medicine in America.

Unfortunately there were not nearly as many registrant as had been expected. The total registration was sixty-two About one half of these were nurses in industry.

The small registration is hard to explain. The cours was well planned and the speakers were outstanding in thei particular fields. Perhaps the season of the year was bad o the hours of the day conflicted with other commitment which the doctors had made.

The committee intends to explore the question fully t try and determine whether to continue to request thi course and if so to try and correct the defects.

Respectfully submitted,
T. P. Murdock

REPORT OF THE SPECIAL RADIOLOGICAL COMMITTEE

Ralph T. Ogden, *Chairman*

Berkley M. Parmelee — Hugh M. Wilson

The Special Radiological Committee on Hospital Radiologist Relations has not met during the past year. It is suggested, however, that this committee be kept in existence for one more year as there are certain possibilities on the horizon that may or may not mature.

Respectfully submitted,
Ralph T. Ogden

Seward and Monde
Certified Public Accountants
205 Church Street
New Haven 10, Connecticut

The Connecticut State Medical Society
New Haven, Connecticut

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1947 and the statements of income and surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society, and without making

detailed audit of the transactions, have examined or tested ccounting records of the Society and other supporting vidence by methods and to the extent we deemed appropriate.

urrent Funds:

Cash in banks, reconciled and confirmed by direct correspondence with the depositories, is accounted for as llows:

ommercial accounts:		
Phoenix State Bank and Trust Company	$4,892.92	
The Capitol National Bank and Trust Company—Journal revolving fund....	2,500.00	
The Second National Bank and Trust Company—Executive secretary revolving fund	3,000.00	
The Second National Bank, Trust Department	1,413.29	
		$11,806.21
vings accounts:		
The New Haven Savings Bank	$7,671.45	
Connecticut Savings Bank of New Haven	7,671.46	
National Savings Bank of New Haven	5,162.62	
Chelsea Savings Bank of Norwich	7,773.81	
		28,279.34
		$40,085.55
tty cash—Journal office		5.00
Total		$40,090.55

On March 9, 1948, we examined, at the Second National nk, the following United States treasury bonds:

RATE AND MATURITY	DECEMBER 31, 1947 VALUE PER BOOKS	MARKET VALUE
2 %, 1953	$ 2,500.00	$ 2,534.38
2½%, 1969	2,500.00	2,518.75
2½%, 1970	5,000.00	5,037.50
2½%, 1971	2,500.00	2,534.38
Total	$12,500.00	$12,625.01

Dues receivable of $1,584 are segregated by counties as llows:

COUNTY	AMOUNT
irfield	$ 214.00
iddlesex	88.00
tchfield	—
ew London	69.00
artford	440.00
ew Haven	731.50
olland	20.00
indham	21.50
Total	$ 1,584.00

Accounts receivable—Journal of $1,057.81 consist of 1947 lvertising accounts which were paid in 1948.

Accounts payable—Journal of $690.01 represents amounts ıe for printing expenses.

The following is a comparison of budgeted and actual general expenses:

	BUDGET	ACTUAL	ACTUAL OVER OR (UNDER) BUDGET
Secretary's office	$25,700.00	$24,758.95	($ 941.05)
Treasurer's office	1,480.00	1,355.37	(124.63)
General	2,750.00	1,791.73	(958.27)
Public relations	5,650.00	5,615.63	(34.37)
Committee allotments	2,050.00	1,855.72	(194.28)
Building fund	1,000.00	796.71	(203.29)
Journal	25,625.00	26,060.29	435.29
Totals	$64,255.00	$62,234.40	($ 2,020.60)

Annual meeting cash of $6,208.32 was confirmed directly to us by the New Milford Savings Bank.

Gurdon W. Russell Fund:

Cash of $2,779.14 in the Mechanics Savings Bank, Hartford, was confirmed by direct correspondence.

We examined the following securities held by this fund:

PAR VALUE	VALUE DECEMBER 31, 1947 PER BOOKS	MARKET
$691.12 New York, New Haven and Hartford Railroad Co. 4% due 2007	$ 458.00	$ 458.00
$985.61 New York, New Haven and Hartford Railroad Co. 4½% due 2022	338.00	338.00
$523.27 New York, New Haven and Hartford Railroad Co. 5% Series A	134.00	134.00
$1,000.00 Boston and Albany Railroad Company, 4½% improvement bonds, due August 1, 1978	820.00	700.00
$5,000.00 U. S. Treasury bonds, 2¼% due 1959	5,000.00	5,062.50
Totals	$6,750.00	$6,692.50

The $2,000 Consolidated Railway Companys, 4% debenture bonds due July 1, 1954, having a book value of $230, were exchanged during the year for New York, New Haven and Hartford Railroad Company bonds, noted above, having a market value at December 31, 1947 of $930. The increase of $700 has been added to the book value of this fund.

O. C. Smith Fund:

We confirmed the principal and income cash in the Mechanics Savings Bank, Hartford, by direct correspondence.

Clinical Congress:

Cash of $4,497.27 was confirmed directly by the New Haven Savings Bank.

Building Fund:

Cash in banks, which was confirmed directly with the depositories, is accounted for as follows:

Savings Bank of New Britain	$ 6,347.50
Mechanics and Farmers Savings Bank of Bridgeport	10,394.69
Milford Savings Bank	10,100.00
City Savings Bank of Bridgeport	10,140.10
Bridgeport Peoples Savings Bank	10,919.40

Norwich Savings Bank	1,032.15
Waterbury Savings Bank	7,417.00
Total	$56,350.84

Expenses of $796.71 incidental to the building fund are included as general expenses.

In our opinion, the accompanying balance sheet and related statements of income and surplus present fairly the position of The Connecticut State Medical Society at December 31, 1947, and the results of its operations for the year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Seward & Monde,
Certified Public Accountants

New Haven, Connecticut
March 24, 1948

Balance Sheet, December 31, 1947

GENERAL FUND

ASSETS

Cash	$40,090.55
United States Treasury bonds (market value $12,625.01)	12,500.00
Dues receivable—1947	1,584.00
Accounts receivable—Journal advertising	1,057.81
Total	$55,232.36

LIABILITIES

Accounts payable:		
Journal	$ 690.01	
County dues	167.50	
Accrued commissions—1947 dues	83.22	
Surplus	54,291.63	
Total		$55,232.36

ANNUAL MEETING FUND

Cash—New Milford Savings Bank	$ 6,208.32
Surplus	$ 6,208.32

SPECIAL FUNDS

Gurdon W. Russell Fund:		
Cash	$ 2,799.14	
Securities (market value $6,692.50)	6,750.00	
		$ 9,549.14
O. C. Smith Trust Fund:		
Principal cash	$ 1,000.00	
Income cash	260.45	1,260.45
Clinical Congress—cash		4,497.27
Building Fund:		
Cash	$56,350.84	
Land	12,270.31	
Architect fees	1,419.30	
		70,040.45
Total		$ 85,347.31
Grand total		$146,787.99

Gurdon W. Russell Fund—capital	$ 9,549.14
O. C. Smith Trust Fund—capital	1,260.45
Clinical Congress—capital	4,497.27
Building Fund—capital	70,040.45
Total	$ 85,34
Grand total	$146,78

Statement of Income and Surplus
General Fund
Year ended December 31, 1947

Income:		
Dues earned	$43,223.00	
Less, Commissions paid	467.43	
		$42,75
Interest on investments		77
Gross income		$43,52
Expenses:		
Secretary's office	$24,758.95	
Treasurer's office	1,355.37	
General	1,791.73	
Public relations	5,615.63	
Committee allotments	1,855.72	
Building	796.71	
		36,174
Excess of general income over expenses		$ 7,35
Less, Excess of expenses over income—Journal operations		3,17
Net income, Year ended December 31, 1947		$ 4,17
Surplus—Balance January 1, 1947	$50,089.63	
Add, Adjustment of 1946 dues and commissions, net	22.22	
		50,111
Surplus—Balance December 31, 1947		$54,29

Details of Expenses
Year ended December 31, 1947

Secretary's office:	
Salaries	$21,119
Travel and expense	999
Rent	1,020
Light	62
Telephone	368
Printing and postage	610
Office supplies	219
Janitor	163
Bank charges	18
Insurance	36
Publications	42
Miscellaneous	98
Total	$24,758

reasurer's Office:		
Clerical services	$	600.00
Fiscal agent's fee		150.00
Professional fees (auditors)		480.00
Postage and printing		125.37
Total	$	1,355.37
eneral:		
Council	$	442.56
Chairman of council		300.00
Delegates—A.M.A. convention		270.00
House of Delegates—meeting		456.35
Conference of Presidents and Secretaries		112.62
Miscellaneous		210.20
Total	$	1,791.73
ıblic relations:		
Director	$	4,500.00
Travel, printing and supplies		1,115.63
Total	$	5,615.63
ommittees:		
Public policy and legislation	$	122.58
National legislation		49.41
Rural health		26.56
Conference on rural health		101.43
Veterans advisory		220.49
Joint (Pharmaceutical)		100.00
Military history		301.75
Prepaid medical service		184.16
Organization and objectives of the Society		312.18
Council of New England Medical Societies		100.00
Miscellaneous		337.16
Total	$	1,855.72
uilding:		
Taxes	$	388.53
Solicitation		293.89
Maintenance		50.00
Miscellaneous		64.29
Total	$	796.71

Statement of Income
Journal
Year ended December 31, 1947

ıcome:		
Advertising (net of commissions of $2,703.31)	$	20,093.36
Subscriptions		550.50
Reprints		1,787.44
Electrotypes		255.17
Single copy		35.95
Miscellaneous		162.31
	$	22,884.73
Expenses:		
Printing	$	14,522.35
Postage and handling		710.48
Electrotypes		468.27
Reprints		1,603.01
Editors' salaries		4,000.00
Office salaries		2,537.00
Office expense		793.67
Rent		900.00
Telephone		98.47
Editorial board and meeting expense		166.93
Copyrights		24.00
Taxes		13.74
Bonding and insurance		18.50
Miscellaneous		203.87
		26,060.29
Excess of expenses over income	$	3,175.56

Statement of Income and Surplus
Annual Meeting Fund
Year ended December 31, 1947

Income:		
Registrations and luncheons	$	5,025.58
Interest on savings accounts		86.58
	$	5,112.16
Expenses:		
Program	$	698.00
Equipment rental		848.00
Rentals		473.28
Postage and printing		206.17
Meeting expense		86.80
Speakers		126.76
Clerical		99.70
Luncheons		1,904.30
Badges		86.83
Telephone		29.40
House of Delegates meeting		200.80
Miscellaneous		131.97
		4,892.01
Excess of income over expenses	$	220.15
Surplus, Balance January 1, 1947		5,988.17
Surplus, Balance December 31, 1947	$	6,208.32

Statement of Capital
Special Funds
Year ended December 31, 1947

	TOTAL	GURDEON W. RUSSELL FUND	O. C. SMITH TRUST FUND	CLINICAL CONGRESS	BUILDI FUN
Balance, January 1, 1947	$65,913.37	$ 8,910.01	$ 1,314.44	$ 4,363.70	$51,325
Additions:					
Increase in book value of investments	700.00	700.00			
Gifts	18,007.00				18,007
Interest on savings accounts	877.87	57.80	26.01	85.83	708
Interest on bonds	179.00	179.00			
Registrations and luncheon fees	1,932.25			1,932.25	
	$87,609.49	$ 9,846.81	$ 1,340.45	$ 6,381.78	$70,040
Deductions:					
Payments of members' dues	$ 80.00		$ 80.00		
Purchase of office equipment	297.67	$ 297.67			
Lunches	357.97			$ 357.97	
Programs and posters	484.62			484.62	
Services—stenographic and clerical	185.49			185.49	
Stationery and printing	26.09			26.09	
Travel—speakers	441.71			441.71	
Reception	145.52			145.52	
Rental of sound equipment	85.00			85.00	
Telephone	29.45			29.45	
Rent of hall	75.00			75.00	
Badges	49.21			49.21	
Miscellaneous	4.45			4.45	
Totals	$ 2,262.18	$ 297.67	$ 80.00	$ 1,884.51	—
Balance, December 31, 1947	$85,347.31	$ 9,549.14	$ 1,260.45	$ 4,497.27	$70,040.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Robert J. Cook, New Haven
President-elect, Mrs. Charles W. Goff, *West Hartford*
Vice-President, Mrs. James Douglas Gold, Bridgeport
Recording Secretary, Mrs. F. Erwin Tracy, Middletown
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven



Mrs. Charles W. Goff, West Hartford, Conn., newly elected President of the Woman's Auxiliary to the Connecticut State Medical Society

At the last Board meeting of the State Auxiliary n Hartford it was announced that Mr. Francis ussell had contacted Mrs. Cook in regard to the rientation schools of one day for the Auxiliary embers to the mental hospitals. May 5 and 6 are e days suggested. The county presidents will ircularize their membership and it is hoped that e majority will attend.

Mrs. William Mac Shepard, public relations hairman, has suggested to the counties that if they lan to have a Health Day or a Guest Day next fall, e time to start planning is NOW. Mrs. Shepard chairman of the Health Day Committee for Vindham County and knows whereof she speaks.

Mrs. Paul S. Phelps, publicity chairman, wishes to ave the *present* County Publicity chairmen send er the detailed reports of their annual meetings so hat there will be no lapse in the publicity to the OURNAL. The newly appointed chairmen will be dvised by the State shortly thereafter.

The Board meeting was made more than interesting by two guest speakers, Dr. Charles C. Wilson, professor of education and public health at Yale, and Miss Biehusen, executive secretary of the Connecticut survey being carried out by the American Academy of Pediatrics.

Dr. Wilson touched on subjects which should be of interest to all of us—Coordination of Health Agencies, organization of Health Units, big business in Voluntary Health Agencies, Emotional Health Problems, Courses in Health in Secondary Schools, Part time Health Officers, Physicians in Schools, etc. It was a very enlightening discussion and Dr. Wilson was deluged with questions. Miss Biehusen discussed the pediatric survey, which was thought could be covered in 6 months and which is now in its second year. She stated that much duplication of health work is discovered and that lack of personnel and of means of obtaining money to carry on the work are handicaps. Everyone was so interested in the talks it is hoped that we may have many more.

It was a pleasure to have Dr. E. Myles Standish of our Advisory Council with us on that day.

FAIRFIELD COUNTY

Officers were elected for the year when the Woman's Auxilary to the Fairfield County Medical Association met at its annual luncheon at Chimney Corners in Stamford. Mrs. Oliver Stringfield presided. The guest speaker was Dr. Jane Oltman, clinical director at the Fairfield State Hospital, Newtown.

HARTFORD COUNTY

Mrs. Edmund Beizer opened her home for the Board meeting of the Woman's Auxiliary to the Hartford County Medical Association when final plans were discussed for the annual meeting at the Hartford Golf Club. The guest speaker, Dr. Howard

W. Haggard, professor of physiology at Yale University, is the well known author of "Devils, Drugs and Doctors," "The Lame, Halt and the Blind," "Mystery Magic in Medicine," and other books. Dr. Haggard's subject for the meeting was "The Modern Problem of Alcoholism."

Mrs. Alfred Sundquist, chairman of the Welfare Committee reported that 400 attended the tea that the Auxiliary sponsored at a meeting for the parents and educators of deaf and hard of hearing children. Mrs. Spencer Tracy was the main speaker. Mrs. Sundquist also stated that additional movies had been shown to homebound children and that an Easter party had been arranged for them. Also, two CARE packages had been sent abroad. There was an interesting discussion of projects for the coming year. Mrs. J. Whitfield Larrabee made arrangements to staff a cancer booth at the Railroad Station from April 5-10.

LITCHFIELD COUNTY

Mrs. F. L. Polito presided at a board meeting held at her home when a nominating committee was elected and plans for the annual spring meeting were made.

Dr. Joseph Howard of Bridgeport was the guest speaker of the Thomaston Parent and Teacher Association at the Thomaston High School Auditorium.

NEW HAVEN COUNTY

Hygeia heads the news notes this month. Mrs. Barnett P. Freedman of New Haven, county chairman of *Hygeia*, received notification that New Haven County had won 3rd place in Group IV (counties with 100 or more members) with a final showing of 135 per cent over quota! We were assigned a quota of 197 credits and Mrs. Freedman's final report showed a total of 245 credits. Subscriptions were divided as follows: New Haven 61; West Haven 13; Meriden 7; Waterbury 3; East Haven 2; and Derby 1.

The prize of $15 will be placed in a fund, the proceeds of which will be used to furnish comp mentary subscriptions of *Hygeia* to school teache in New Haven County whose program emphasiz hygiene.

Miss Agnes V. Ohlsen, executive secretary of tl State Board of Nurse Examiners, addressed tl assembly of doctors' wives at the annual luncheo meeting held at the Oakdale Tavern in Wallingfor

WINDHAM COUNTY

The Windham County Auxiliary has been mo than active this month. The executive commitee m at the home of Mrs. William Mac Shepard in Pu nam. Plans were completed for the spring meetir of the Auxiliary held at the Mansfield Trainir School.

There was a most successful dinner party at th General Lyon Inn in Eastford. Forty doctors an their wives were present. Everyone had a ver delightful time.

Health Day in Putnam. A program is to be pu on at the Putnam High School in which various o ganizations are to have exhibits demonstrating the health programs. Among those taking part are th Boy Scouts, Girl Scouts, Visiting Nurse Associatio The American Red Cross, Four H Club, and th Hygiene Department at the High School. This is i addition to the main speaker. Invitations will g out to the key people and organizations in the su rounding towns very shortly. About 300 will b sent. Mrs. Shepard is arranging the Health Da program.

New Haven County Auxiliary Honored

The Woman's Auxiliary to the New Have County Medical Association has been awarded thir prize in a national subscripton contest for *Hygeia* the monthly health magazine published by th American Medical Association. It was recently an nounced that the Auxiliary will use the prize mone to furnish free subscriptions to *Hygeia* for teacher of health and hygiene in the public schools.

SPECIAL NOTICES

Preliminary Program

NEW ENGLAND CONFERENCE OF INDUSTRIAL PHYSICIANS AND SURGEONS

Spring Meeting

Hotel Bond, Hartford, Thursday, May 27

ponsored by the Committee on Industrial Health, Connecticut State Medical Society, with the co-peration of the Manufacturers Association of Connecticut, Connecticut State Nurses' Association and he Connecticut Safety Society.

0:00 Registration

MORNING SESSION

11:00 A. M. TO 12:30 P. M.

residing, J. Robertson Knowles, M.D., *President, New England Conference of Industrial Physicians and Surgeons*

C. Frederick Yeager, M.D., *Chairman,* Committee on Industrial Health, Connecticut State *Medical Society*

Industry's Interests in Health and Safety Services"

(Speaker to be announced)

The Medical Profession's Interest in Industrial Health and Safety"

Creighton Barker, M.D., *Executive Secretary, Connecticut State Medical Society*

Newer Opportunities and Responsibilities in Industrial Health and Safety Services"

Daniel L. Lynch, M.D., *New England Conference of Industrial Physicans and Surgeons*

2:30 Luncheon

AFTERNOON SESSION

2:00 TO 4:30 P. M.

Presiding, Donald J. Baker, M.D., *Vice-President New England Conference of Industrial Physicians and Surgeons*

Panel Discussion: "Cooperative Relationships of Medical, Nursing, and Safety Services in ndustry"

(1) Viewpoint of Industry

Robert Collins, *Director of Personnel, New Departure Divsion, General Motors Corp.*

(2) Viewpoint of Industrial Nursing

Mrs. Mary Delehanty, *President, American Association of Industrial Nurses*

(3) Viewpoint of Industrial Safety
Everett W. Martin, *Liberty Mutual Insurance Company*

(4) Viewpoint of Medicine
(Speaker to be announced)

(5) General Discussion

3:30 "Training of Industrial Physicians and Nurses"
Ronald F. Buchan, M.D., *Clinical Director, Yale Institute of Occupational Medicine an Hygiene*

"Health Service in Small Industries"
Robert L. Quimby, M.D., *Hartford*

Discussion
Stanley Sprague, M.D., *leader, New England Association of Industrial Physicians and Surgeo*

4:30 Business Session

DINNER MEETING

6:30 to 9:00 P. M.

Presiding, J. Robertson Knowles, M.D. C. Frederick Yeager, M.D.

Address: "How Industry Looks at its Health and Safety Services"
(Speaker to be announced)

For Advance Reservations: Crit Pharris, M.D., *Chairman*, Pratt and Whitney Division, United Aircra Corporation, East Hartford, Connecticut

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GUEST SPEAKERS, HARTFORD HOSPITAL MEDICAL AMPHITHEATRE

10-11 o'clock Saturday Mornings

April 24
Dr. John Lockwood, Professor of Research Surgery, Columbia Presbyterian Medical Center
"Influence of Chemotherpy on the Modification of Surgical Principles"

May 1
Dr. Paul Swett, Consulting Orthopedic Surgeon, Hartford Hospital
"Psychosomatic Aspects of Orthopedic Conditions"

May 8
Dr. Averill Liebow, Assistant Professor of Pathology, Yale University School of Medicine—Clinical Pathological Conference

May 15
Dr. Byron Smith, New York
"The Eye Bank"

May 22
Dr. Paul H. Twaddle, Chief of Cardiology Service, Ha for Hospital
"Consideration of the Precordial Leads in the E.K.(

May 29
Dr. E. Myles Standish, Visiting Dermatologist, Hartfo Hospital
"Dermatology" (with Kodachrome Slides)

June 5
Dr. J. Raglan Miller, Visiting Gynecologist, Hartfo Hospital
"Recent Advances in Gynecology"

June 12
Dr. Sydney Farber, Professor of Pathology at Harva Medical School, and Pathologist at Children's Hospit Boston
"Chemotherapy of Cancer"

June 19 (Tentative)
Dr. Oliver Cope, Massachusetts General Hospital
"The Importance of Protein Therapy in Post Operati Care"

All physicians are cordially invited to attend.

NATIONAL CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Sunday, June 20, 1948, 2:00 P. M. to 5:30 P. M.
Palmer House, Chicago

THE JOB OF THE COUNTY MEDICAL SOCIETY
(Three Panel Discussions)

Moderator: A. M. Mitchell, M.D., Terre Haute, Indiana

1:0 P. M.
Registration

2:0 P. M. TO 2:45 P. M.

. The County Medical Society—Its Part in Medical Organization

A. Relation to the State Medical Association

B. Relation to the American Medical Association

C. Relation to Other Medical Organizations—N. P. C., A. A. P. S., Blue Cross, A. M. C. P., Academy of General Practice, etc.

Discussant: F. J. Holroyd, M.D., Princeton, West Virginia (15 Min.)

Question and Answer Period

2:5 P. M. TO 4:00 P. M.

I. The County Medical Society—Its Responsibility to the Membership

A. Organization Responsibilities

1. Membership—Selection and Maintenance
2. Censorship—Maintaining Ethics
3. Hospital Relations

Discussant: T. J. Danaher, M.D., Torrington, Connecticut (12 Min.)

B. Scientific Programming

Discussant: C. J. Milling, M.D., Columbia, South Carolina (12 Min.)

C. Fellowship and Business

1. Social Functions—Golf, Bowling, Parties
2. Business Aids—Credit and Collection, Telephone Answering Service, etc.

Discussant: C. L. Mulfinger, M.D., Los Angeles, California (12 Min.)

Question and Answer Period

4:0 P. M. TO 5:30 P. M.

III. The County Medical Society—Its Responsibility to the Public

A. Medical Care—Serving the Public

1. Pay Patients
2. Medically Indigent
3. Indigent—Government Clients

Discussant: D. B. Wiley, M.D., Utica, Michigan (15 Min.)

B. Community Agencies—The Growing Demand of These Agencies Requires Serious Consideration

1. Special Programs—Participation in Cancer, Tuberculosis, Heart, etc. programs
2. Community Chest—The Place of the Medical Profession in the Drives for Funds
3. Health Councils—The Function of the Medical Society

Discussants: W. E. Nissen, M.D., Albuquerque, New Mexico
and
B. O. Mork, Jr., M.D., Worthington, Minnesota
(10 Min. each)

C. Newspapers, Radio, Industry, and Labor

Discussant: John D. Bibb, M.D., Reno, Nevada

D. Legislative-Political Responsibilities of the County Medical Society

Discussant: R. B. Robins, M.D., Camden, Arkansas (10 Min.)

Question and Answer Period

CONNECTICUT VETERANS ADMINISTRATION MEDICAL SOCIETY

May 6

Hepatitis

Dr. Robert Levin, Associate Physician, Veterans Administration Regional Office, Hartford

May 13

Errors in Diagnosis of Heart Disease

Dr. Morris Dressler, Chief Cardiologist, Veterans Administration Regional Office, Hartford

May 20

Shoulder Lesions

Dr. Walter Dalmain, Orthopedic Specialist, Veterans Administration Regional Office, Hartford; Assistant Visiting Surgeon, Newington Hospital for Crippled Children

May 27

Fungus Infections

Dr. Albert Rubin, Specialist in Dermatology, McCook Memorial Hospital, Mt. Sinai Hospital and Hartford Dispensary

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LONG ISLAND COLLEGE OF MEDICINE ALUMNI DAY

Saturday, May 8, 1948

68th Annual Dinner, Knights of Columbus Club, Grand Ballroom, Prospect Park West and Union Street, Brooklyn, New York.

Tickets $8:00.* Cocktails 7:00-8:00 P. M.
Dress optional. Dinner promptly at 8:00 P. M.

Speakers

Dr. A. W. Martin Marino, President, Alumni Association
Dr. J. A. Curran, President, Long Island College of Medicine

Entertainment

The 25 year class (Class of 1923) will be seated at the large table in front of the dais. The 50 year class (Class of 1898) will be seated on the dais.

There will be a short business meeting immediately after the program.

Amendment to Article VII of the By-Laws proposed and approved by the Board of Managers:

"The Annual Dues shall be Five ($5.00) Dollars and payable on May the first."

To be voted upon at this meeting.

No solicitation. Please make checks payable to Alumni Association, Long Island College of Medicine, 350 Henry Street, Brooklyn 2, New York. Please make dinner reservations before May 3, 1948.

*Price of ticket includes cocktails and gratuities.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-sixth annual scientific and clinical session September 7, 8, 9, 10 and 11 inclusive, at the Hotel Statler, Washington, D. C. Scientific and clinical sessions will be given the days of September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 7, 8, 9 and 10. These courses will be offered in two groups. One set of ten lectures will be based primarily on physics and psysiology and attendance will be limited to physicians. One set of 10 lectures will be more general in character and will be open to physicians as well as to physical therapists. The physical therapists must be registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

CHICAGO POSTGRADUATE COURSES

The Chicago Medical Society is offering physicians of the country two postgraduate courses in September. A course in Hematology and Neurology will be given September 13-18 and another in Cardiovascular and Respiratory Diseases will be given September 20-25.

The sessions will be held in Thorne Hall on Northwestern University Medical School campus.

An outstanding group of teachers from all sections of the United States will make up the faculty.

Information may be secured by writing the Chairman, Committee on Postgraduate Medical Education, Chicago Medical Society, 30 North Michigan Avenue, Chicago 2, Illinois.

ARTISTS, BEWARE!

If you plan to exhibit at the Chicago Exhibition (American Medical Association, June 21-25, 1948)—Now is the time to write for entry blanks, rules, shipping labels, etc.

Haste is necessary because your entries must reach Chicago between May 1 and June 12.

For details, please write airmail to Francis H. Redewill, M.D., Secretary, American Physicians Art Associati Flood Building, San Francisco, California.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

The general oral and pathology examinations (Part for all candidates will be conducted at Washington, D. by the entire Board from Sunday, May 16, through Sat day, May 22, 1948. The Shoreham Hotel in Washingt will be the headquarters for the Board. Formal notice the exact time of each candidate's examination will be s him several weeks in advance of the examination dat Hotel reservations may be made by writing direct to t Shoreham.

Candidates for re-examination in Part II must make wr ten application to the Secretary's office not later than Ap 1, 1948.

Candidates in military or Naval Service are requested keep the Secretary's office informed of any change address.

Applications are now being received for the 1949 exa inations. For further information and application blan address Paul Titus, M.D., Secretary, 1015 Highland Buil ing, Pittsburgh 6, Pennsylvania.

AMERICAN PHYSIOTHERAPY ASSOCIATIO ANNUAL CONFERENCE

The American Physiotherapy Association will hold annual conference at the LaSalle Hotel, Chicago, M 23-28.

An outstanding program has been prepared presenti such authorities as Hart E. Van Riper, M.D., medic director of the National Foundation for Infantile Paralys Louis B. Newman, M.D., chief of physical medicine r habilitation, V. A. Hospital, Hines, Illinois; Sumner Koch, M.D., professor of surgery, Northwestern Universi Medical School; Harry D. Bowman, M.D., professor physical medicine, University of Wisconsin; and Robe L. Bennett, M.D., director of physical medicine, Georg Warm Springs Foundation.

There will be movies, exhibits, and tours to the Physic Therapy Departments in Chicago. The House of Delegat will meet in general session on three of the days.

AMERICAN ASSOCIATION OF THE HISTOR OF MEDICINE

The 21st annual meeting of the American Associatio of the History of Medicine will be held at the College Physicians, Philadelphia, May 26 and 27.

There will be two general sessions on the 1st day ar one general session on the 2nd day. At the 1st general se sion there will be a symposium on "The Physician in th 18th Century." "The Place of History in Medical Educ tion" will be discussed at the 2nd general session and o the 2nd day of the meeting there will be papers on mi

aneous subjects by members of the Association.

Hotel reservations should be made by writing Mr. Michael McGarry, Penn-Sheraton Hotel.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION

The National Gastroenterological Association will hold Thirteenth Scientific Session at the Hotel Pennsylvania New York City on June 7-10.

n response to popular request the program this year will in for the most part consist of Symposia and there will one Panel Discussion.

The program for the first three days will be at the Hotel nsylvania and will consist of Symposia on Gastroduod- l Ulcer; Ulcerative Colitis; Jaundice and Metabolism, trition and Allergy. The Panel Discussion which will followed by a "question and answer" period will cover topics of Diabetic, Tubercular, Psychosomatic and Car- Manifestations in Gastrointestinal Diseases.

The fourth day of the session will be devoted to a ical day at cooperating hospitals in New York City.

t the Annual Banquet to be held on Tuesday evening, e 8, the winner of the National Gastroenterological ociation's 1948 Cash Prize Award Contest for the best ublished contribution on Gastroenterology or an allied ject will receive the prize of $100 and a Certificate of rit.

urther details and a copy of the program may be ob- ed by writing to the Secretary, National Gastroentero- ical Association, 1819 Broadway, New York 23, New rk.

GREENWICH HOSPITAL TUMOR CLINIC

The Tumor Clinic of the Greenwich Hospital is held 11:00 A. M. on alternate Tuesdays. Chairman: Sidney A. ompson, M.D.

The Greenwich Hospital Tumor Clinic has recently been led to the list published by the State Division of Cancer search.

AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D. C., MAY 17-20

Psychiatric Developments in the Treatment of Mental eases—in the veterans administration, state institutions, eral hospitals, and in home, school and job adjustments the community—are included in the comprehensive pro- m planned for the 104th annual meeting of the American chiatric Association, to be held Monday, May 17, ough Thursday, May 20 at the Statler Hotel in Wash- ton, D. C. More than one hundred papers will be pre- ted.

OUR NEIGHBORS

Massachusetts

On or before June 30 the American National Red Cross will take over the blood program activities in Massachusetts from the State Department of Public Health. This transfer has the approval of the Massachusetts Medical Society. The Blood Processing Laboratory of the Massachusetts Department of Public Health will continue to function as a fractionation unit. Research will continue to be carried on to improve and develop fractionation methods.

The statewide program in Massachusetts has entered its third year. Already it has saved residents of that State thousands of dollars annually by providing blood and blood products free of charge.

* * * *

The Massachusetts Blue Cross found itself in financial difficulties at the beginning of 1948. Reginald H. Cahalane, plan director, has resigned. There was an operating deficit for 1947 of $1,700,000, two hospitals have withdrawn, and a $9,000,000 gap between ideal and actual reserves showed up.

The causes for the present crisis are many, some old, some new. Among them are a high usage rate which is the result of poor screening of "floaters" who join the plan for an anticipated hospitalization and then drop out, a failure in the past to collect and interpret actuarial data upon which to base equitable rates, general inflation, and a too liberal coverage which includes a number of medical services.

Referring to the last named item, Roger W. Hardy, new plan director and prominent Boston attorney, stated, "Although we are a public service organization, we have been forced to realize we are not a substitute for the community fund."

New York

A proposed plan has been announced for the union of the properties and programs of the New York Post-Graduate Medical School and Hospital and New York University-Bellevue Medical Center. The proposed union is in line with the recommenda-

tion of an overall plan of hospitals for the city as prepared by the Hospital Council of Greater New York. This plan stresses the importance of central teaching hospital facilities and the necessity for teaching and training opportunities in all hospitals. The two institutions under the proposed union would actually merge their assets, buildings, and programs.

* * * *

New York University is the recipient of a bequest estimated at more than $400,000 from the estate of the late widow of Dr. Joseph Talbot Maclean. The terms of the bequest stipulate that income from it shall be applied to carrying on medical research, and the University plans to devote the money to research projects that will be carried out by the New York University-Bellevue Medical Center. Dr. Maclean was a graduate of the Bellevue Hospital Medical College, class of 1876, this institution later having been consolidated—in 1898—with the University's medical school. After years of practice in Ohio and New York, Dr. Maclean died in 1920.

* * * *

The Medical Society of the County of New York will seek a change in the constitution of the American Medical Association whereby certain Negro physicians now barred may become eligible for membership in the AMA.

NEWS
from County Associations

Fairfield

Margaret D. Craighill of Topeka, Kansas, a member of the Fairfield County Medical Association, is the author of "Psychiatric Aspects of Women Serving in the Army" published in the *American Journal of Psychiatry*, October 1947.

Hartford

James Raglan Miller, member of the Board of Trustees of the AMA, addressed the 1947 annual meeting of the New Hampshire Medical Society on "Internal Public Relations." His presentation was published in the *New England Journal of Medicine*, February 26, 1948.

Walter F. Jennings is now associated with Charl W. Goff, 30 Farmington Avenue, Hartford, in th practice of orthopedic surgery. Dr. Jennings is graduate of Rush, interned at Kings County Ho pital and spent five years in military service devote to orthopedic surgery. He has just completed h adult orthopedic training with Dr. Compere i Chicago.

Charles W. Goff has been appointed to the Po ture Committee of the American Academy Orthopedic Surgeons. He is also serving on the Ne England Regional Committee of the Academy.

Litchfield

Thomas J. Danaher of Torrington is a membe of the Committee on Arrangements for the Nationa Conference of County Medical Society Officers t be held at the Palmer House, Chicago, June 20. D Danaher will discuss "Organization Responsibilitie of the County Medical Society" at this session.

Thomas J. Danaher, chief of staff at Charlott Hungerford Hospital, Torrington, has been electe president of the Torrington Community Chest. D Danaher served as chairman of the last two Ches campaigns.

New Haven

Lieutenant David L. Smith, MC—USA, son of D and Mrs. David P. Smith of Meriden, has sailed fo Germany where he will remain approximately on year. Lieutenant Smith interned in pediatrics a Boston City Hospital and completed a 3 mont course in pediatrics at Walter Reed Hospital.

Theodore D. Pallman, one of New Haven's olde practitioners of medicine, died March 4 at his hom after an illness of 3 weeks. Dr. Pallman was physi cian for the New Haven County jail at the time o the severe fire there in 1910 when six firemen wer killed and many prisoners injured.

Bronislaw L. Smykowski of Meriden was honore on April 11 by a testimonial dinner given him b the Polish Roman Catholic parishes of Connecticut The dinner was in honor of the Knighthood of th Order of St. Gregory the Great, Civil Class, con ferred in March upon Dr. Smykowski by Hi Holiness Pope Pius XII.

The speaker for the New Haven Medical Asso ciation meeting held on April 7 was Dr. I. C. Rubi of Columbia University whose subject was "Ster ility and Infertility."



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The following are members of the New Haven County Medical Association who died in 1947 or 1948: Edward P. Lehman, 1900-1947; Harry H. Maynard, 1887-1948; Ralph E. McDonnell, 1894-1947; James L. Moriarty, 1871-1947; Edward K. Parmelee, 1867-1947; Randolph Raynolds, 1886-1947; Clarence E. Skinner, 1868-1947; Harry E. Stewart, 1887-1948; Alexander W. Winkler, 1908-1947; William N. Winne, 1872-1947.

New London

In January 1948 the W. W. Backus Hospital of Norwich established a fulltime Department of Anesthesia under the direction of Dr. Louis R. Orkin. The leader comes to the hospital well qualified. He is a graduate of University of Wisconsin 1937; a graduate of medicine from the New York University Medical College in 1941; served in the Armed Forces, 6 months in Oregon and 1½ years in Italy. He was resident anesthetist at Bellevue Hospital, New York City and later was the chief resident anesthetist at the same hospital for 6 months. These services were under the expert direction of Dr. E. A. R. Rovenstine. The hospital is to be congratulated on two important points, the establishment of a fulltime Department of Anesthesia, and the ability to secure the services of such a well trained man.

To establish a fitting memorial to the deceased members, the Norwich Lodge of Elks donated the sum of $10,000 for the erection of a blood bank. Work has been started upon this project. It is fitting that such a project should coincide with the 50th anniversary of the local chapter. The blood bank will consist of a waiting room, a donor room, and a fully equipped laboratory furnished in stainless steel and chrome plating. When completed it will probably be the best and most modern of its type and a great blessing to the community, thanks to B. P. O. E.

The annual meeting of the New London County Medical Association was held at the Seaside Sanatorium, Waterford. There was a good attendance despite the inclement weather and those present were rewarded with a good meeting, a splendid dinner as the guests of Dr. John F. O'Brien, superintendent of the sanatorium, and an excellent scientific session and paper at 8 P. M., given by Dr. Julian B. Herrmann, surgeon of the Pack Medical Group, Memorial Hospital, New York City. The subject was "Hormonal Therapy of Breast Cancer." A lively discussion followed with many questior asked. At the afternoon business session the follow ing officers were elected to office: President, Henr Archambault, Taftville; Vice-President, C. Joh Satti, New London; Secretary-Treasurer, Thom Soltz, New London; and Councilor, George H Gildersleeve, Norwich.

The following men were elected to membership Louis Guss, Norwich; Harold William Duennebie Niantic; James David Sawyer, Jewett City.

George H. Gildersleeve of Norwich has bee appointed medical examiner for Bozrah, Franklir Lebanon, Preston and Ledyard, in addition to Nor wich.

Tolland

Frank B. Converse, 82 years old and dean of To land County physicians, died April 4 at his home i West Willington. Dr. Converse had served this are as a country doctor for 50 years until he retired fror practice in 1943. It was in October of that yea that the Tolland County Association honored hir with a testimonial dinner.

News from Yale University School of Medicine

Dr. Lindskog Promoted

Gustaf E. Lindskog has been appointed chairma of the department of surgery and promoted to b William H. Carmalt professor of surgery to succee Samuel C. Harvey. Dr. Lindskog is known as a expert in thoracic surgery and is a consultant t the VA Hospital in Newington.

New Theory in Interpreting Electrocardiograms

Announcement of a new theory for interpretin electrocardiograms was made recently by Yal School of Medicine investigators. The new theor upsets ideas held for a quarter of a century on th interpretation of electrocardiograms and for the firs time shows exactly which portion of the heart con tributes to each section of an electrocardiogram. I is expected to make part of the diagnosis of hear ailments more accurate and easier to understand by the practicing physician.

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The Yale research is expected to permit more accurate localization of points of injury in the heart than are now possible. For example, the point at which a blood clot may have formed can now be spotted more exactly in the electrocardiogram.

It has been known for some time that even in normal hearts the heart will often skip a beat. The new theory can show where such skips originate.

The previously held concept of the nature of the electrocardiogram is known as the cavity potential theory. Its explanations for the wavy lines and curves of the electrocardiogram are based on the idea that the cavities of the heart are the first to receive electrical impulses. As they spread from the cavities of the heart externally to the surface, differences appear on the electrocardiogram. The Yale investigators felt that this explanation was unsatisfactory.

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NEW BOOKS IN REVIEW

BRIEF PSYCHOTHERAPY—A Handbook for Physician on the Clinical Aspects of Neuroses. By Bertrand S. Frohman, M.D., with the collaboration of *Evelyn P. Frohman. Philadelphia: Lea & Febiger.* 1948. 265 pp. $4.

Reviewed by GEORGE A. GOSSELIN

This concise first edition on Brief Psychotherapy by Bertrand S. Frohman with collaboration of Evelyn P. Frohman, rather lives up to its title. If a reviewer were free to do so, the review would be Walter Alvarez's foreword verbatim. The author's wide experience in general practice prior to specific interest in psychotherapeutic procedure is undoubtedly responsible for the physicial set up of this volume. There is emphasis on psychosomatics which one feels could be somewhat more elaborated upon from the viewpoint of pharmacological measures, so lacking in most volumes on the subject.

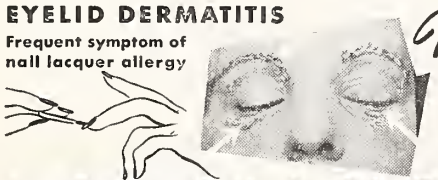
The author's 10 years in general practice and 15 years in psychotherapy certainly qualify him to discuss the subject from the broader viewpoint which it was his aim to emphasize. Certainly one agrees with the author that biochemical and neurophysical factors are highly essential in the diagnosis and therapy of any abnormal state. Continued disturbed function must eventually produce organic changes, relatively speaking.

In the chapter on neuroses Dr. Frohman stresses the importance of the knowledge of the psychogenesis of common complaints as far as the general practictioner is concerned. He also has paid special attention to the effects of psychic reactions in some of the specialties as urology, endocrinology, surgery, gynecology, and pediatrics. His years of general practice would account for this emphasis. However, one cannot quite agree that certain dermatological conditions are "often" precipitated by psychogenetic factors, as, for instance, herpes zoster, psoriastis, neurodermatitis, etc. One usually assumes there is a toxic or infectious factor in these conditions.

There is a relatively brief description of psycho analysis, its procedures and the well known masters in the field.

The description of the neuroses covers etiology and therapeutics procedures along with constitutional factors related to each symptom group. There are short and descriptive case histories which are illustrative of each point the author wishes emphasized. This is especially helpful to those in and out of this special field. One likes the section on "semantics" which is a bit different than the usual approach. The chapter on convulsive therapy, hypnotherapy and narcosynthensis is quite helpful in view of the rapid

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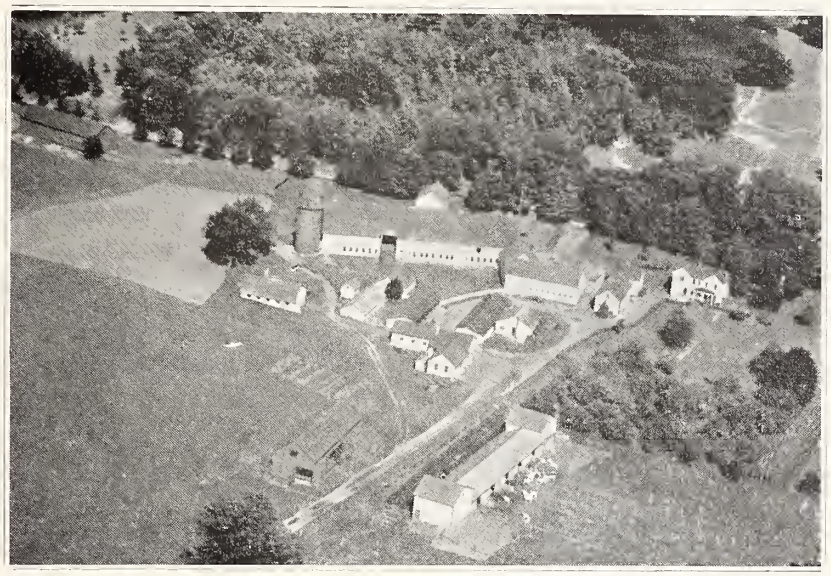
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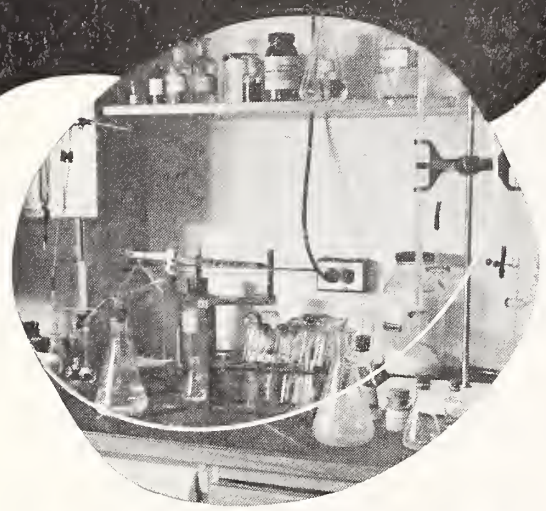
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advances being made each year and because these advane are not too familiar to a great many practitioners.

One does not quite agree that the volume should l place at the disposal of patients. The glossary is fine, b how many suggestions for further complaints could l absorbed by the susceptible neurotic? The more that soundly written for the profession and the less for l reading would seem to be a more constructive attitude. is true, a few highly selected patients should benefit, b how few?

The bibliography is most complete. This volume seer small for the 265 pages it contained and it is very readabl On the whole the conciseness and clarity of the subje material should make this work a "must" in any docto library.

UNIPOLAR LEAD ELECTROCARDIOGRAPHY. *Emanuel Goldberger*, B.S., M.D., Adjunct Physician, Mo tefiore Hospital, New York; Cardiographer and Assoc ate Physician, Lincoln Hospital, New York; Dilplomat American Board of International Medicine; Clinical Le turer in Medicine, Columbia University, Faculty Medicine. *Philadelphia: Lea & Febiger.* 1947. 182 p 88 illus. $4.

Reviewed by ARTHUR J. GEIGER

The traditional development of clinical electrocardi graphy based on bipolar derivations of the various leads h in the past decade, been supplemented by the experiment application of a unipolar technic of derivation whose co cept is that unipolar electrocardiograms represents mo accurately the graphic expressions of the dominant potenti variations occurring sequentially in the relatively limit areas of the heart located nearest (in the case of limb lead or subjacent (in the case of chest leads) to the explorir electrode. Since the introduction of the unipolar techn by Frank N. Wilson in 1934, and its modification b Emanuel Goldberger in 1942, the founders and disciple of the unipolar school have produced a large and som what esoteric literature, the comprehension and clinic application of which has probably been limited to a rath small circle of specialists.

Dr. Goldberger's small monograph performs a valuab service in bringing together, correlating, and attempting t elucidate much of this scattered material for more gener understanding and use. His efforts to simplify succeeds i some parts of the presentation, but the reader will fin many sections difficult to follow and even harder to appl understandingly: for example, the pronounced effects c the graphic patterns by rotations of the heart around on two or even three electrical aces demands considerab mental facility from the comprehending reader and st dent.

The monograph is unique in its comprehensive present tion of unipolar electrocardiography and in its ample refe ences to more detailed aspects of the subject. Since th is not the sort of book that yields all it has to teach in or or even several readings, the novice will want to own an repeatedly refer to a copy.

The implication that the familiar and traditional standar bipolar lead electrocardiography can and may soon l replaced by unipolar electrocardiography would seem t

pend not only on an easier comprehension of an admit-dly difficult subject but also on a more secure delineation the criteria of normal, and on a more acceptable explana-on for the S-T segment and T wave and their changes in normal states.

HE 1947 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY. Edited by J. P. Greenhill, B.S., M.D., F.A.C.S., Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; Attending Obstetrician and Gynecol-ogist, Michael Reese Hospital; Associate Staff, Chicago Lying-In-Hospital; Author of *Office Gynecology* and *Obstetrics in General Practice;* Co-author of the DeLee-Greenhill *Principles and Practice of Obstetrics. Chicago: The Year Book Publishers.* 1948. 590 pp. $3.75.

Reviewed by STANLEY B. WELD

This Year Book contains the usual excellent abstracts the literature on obstetrics and gynecology, domestic id foreign, published from October 1946 to September 47, inclusive. As in previous years, the value of the 1947 ear Book is enhanced by the author's comments which llow many of the abstracts.

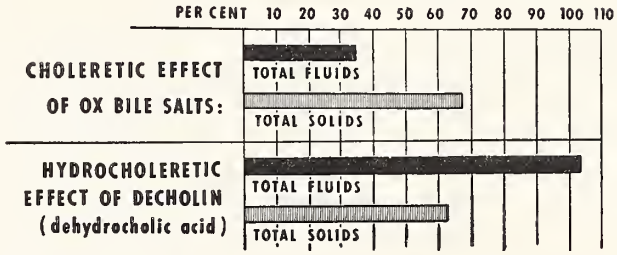
In the field of obstetrics there has developed two oppos-g schools of thought on elective induction of labor. The ajority of writers agree with the editor that "elective duction of labor when performed at the *proper* time by ne who knows how, carries no risks." Two papers are stracted on the use of pituitary extract in labor, one by icholson J. Eastman of Baltimore, the other by Duncan . Reid of Boston. Dr. Greenhill adds a 2-page discussion orth reading.

Herbert Thoms' paper on the "Role of Nutrition in elvic Variation" receives due recognition. There is an undance of literature in abortion. Priscilla White's out-anding work on diabetes in pregnancy is covered by one stract. Several pages are devoted to the toxemias. Of articular note in this group are the clinical trials in late regnancy toxemia based on experimental work by George nd Olive Smith at the Free Hospital for Women in Bos-n. Attention is again drawn to mid plane pelvic contrac-on and to outlet contraction. The literature on analgesia nd anesthesia in labor continues to be abundant. Louis udolph and Charles Field of Chicago and Pierce Rucker f Richmond, Virginia, revive the subject of constriction ng dystocia and provoke a long comment from the editor.

In the puerperium one of the greatest advances is the eatment of breast abscesses with penicillin. The single rticle abstracted appeared in the *British Medical Journal* ut considerable literature on this subject has appeared in ne United States. Many articles on erythroblastosis and the h factor are abstracted.

In the field of gynecology the subject of infertility ssumes a prominent position. Walter W. Williams of pringfield and Fred A. Simmons of Boston appear among he authors of selected articles. The role of hyaluronidase f recent interest is covered by two articles. The use of elatin foam sponges as an aid in hemostasis is reviewed.

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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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The developments in the diagnosis and treatment of cancer of the cervix are well covered. Two articles by Joe V. Meigs of Boston on the use of the vaginal smear are abstracted, as well as several articles on the radical operation for cancer of the cervix including one by this same author. The volume closes with several abstracts dealing with menstruaton and another group from the field of endocrinology.

Obstetricians and gynecologists have found the Year Book invaluable for reference. It needs no sales talk.

COMPULSORY HEALTH INSURANCE. By Elizabeth W. Wilson, PH.D., Member, International Actuarial Congress, London 1927, Rome 1934. *New York: National Industrial Conference Board, Inc.* 1947. 138 pp. $1.

Reviewed by STANLEY B. WELD

This volume offers the most concise discussion of the controversial subject of compulsory health insurance yet published in the United States. The author is definitely prejudiced but as the daughter of a physician she probably has a good right to be. She shows how the demand for increasing government intervention in the field of health has resulted in a long series of state and federal legislative proposals. The government projects from 1912 to 1944 are reviewed. The health insurance laws of Rhode Island and California are outlined and the glaring faults of the former indicated.

When one has finished Dr. Wilson's book it is very clear that the Wagner-Murray-Dingell bill is not the answer to the problem of better medical care. The availability of physicians and nurses to implement such a program, the economic feasibility and the political implications of a compulsory health program are outlined. Then in the final chapter the author sets up in two columns the arguments for and against the various factors involved. The nation's health, the draft rejections, voluntary health insurance plans, and the free choice of physicians, malingering, quality of care, and regimentation under a compulsory health program are tabulated.

The charts and tables are good, the references at the end of each chapter many, and at the close of the book appears a partial list of persons cited in the text. Dr. Wilson has performed well a valuable service to the citizen and taxpayer of our democracy.

THE PRACTICE OF GROUP THERAPY. Edited by S. R. Slavson, Director of Group Therapy at the Jewish Board of Guardians in New York City and Past President of the American Group Therapy Association. *International Universities Press: New York, N. Y.* 1947. 271 pp. $5.

Reviewed by CHARLES T. BINGHAM

This small volume consists of thirteen chapters. Each chapter explains the use and success of group therapy in many types of conditions. Each phase is written by a different author. The authors are doctors of medicine or phil- ophy, psychotherapists or group therapists, professors psychiatry or sociology, psychologists, psychatrists or tea ers, all of whom have had special training and interest group therapy. The essays have all been edited in suc way as to integrate the entire volume and prevent repetiti

It is very apparent from a perusal of this book that t treatment of mental disorders, behavior disorders, a psychosomatic symptoms can often be markedly impro if the sick individuals are treated in groups rather th singly. The sense of comfort as expressed in the ada "misery likes company," which a patient gets by findi others in the same boat with himself, being able to expr himself and seeing his fellows undergoing the same reactio is a very important factor in treating problem cases, b in children and in adults, which all physicians should ke in mind, especially in this era of increased emotional te sion. The prevalence of frustration in human existence a the inadequate number of trained psychiatrists in the ge eral population, both emphasize the advantage and efficien of treating people in groups. For anyone interested in t possibilities and techniques of group therapy, the pres volume is a valuable source of information.

TREATMENT IN GENERAL PRACTICE. (Sixth Ed tion.) *By Harry Beckman*, M.D., Professor of Pharm cology, Marquette University School of Medicine, M waukee, Wisconsin. *Philadelphia & London: W. Saunders Company.* 1948. 1129 pp. $11.50.

Reviewed by JULIUS H. GROWER

In his preface to the sixth edition, the author remar that painstaking teaching of therapeutics in this count is not often the subject of serious consideration in o medical schools as it well might be. Also, that with fe exceptions, ridiculously inadequate courses of lectures a given and the rest is left to the teachers in the departmen of medicine, pediatrics, obstetrics, etc. These latter see to shift the responsibility largely on to the gods becau they are too occupied with acquainting the student wit the methodology of modern diagnosis.

In this volume the author largely succeeds in his effo to outline the newer procedures in therapy in an eas readable and an easy reference work in a clear and inte esting manner. He mentions precise methods which he h selected through long experience and presents the mo practical information in considerable detail and then als includes the less important and debated views in brief.

Therapy for the principal diseases of man are describe exclusive of those of the legitimate specialties, thus makin this book very practical for students and general pract tioners.

When an attempt is made to select chapters which preser particularly the most recent and practical views, the tas is difficult because it is apparent after careful reading an frequent reference that most of the subjects described fi the bill for the most critical.

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FUTURE OF OUR VOLUNTARY HOSPITALS

RAYMOND P. SLOAN, *New York*

The Author. *Editor "The Modern Hospital"*

FOR years we have been talking about the future of our voluntary hospitals. If we do something about the present of our voluntary hospitals the future will take care of itself. And if we don't do something about the present of our voluntary hospitals there isn't going to be any future to worry about. And that's nearer the truth than you may think.

Never before have these institutions faced such crisis. The reasons are obvious—rising costs all along the line. No, your administrator isn't to blame. Some trustees believe that the hospital superintendent is or should be a miracle worker and should be able to keep costs in bound. Before arriving at any such conclusion these trustees had better do a little checking on how well they are succeeding in living within their own budgets. You can't beat the unsailable truth that living costs are higher today than they ever have been.

You probably have read that the United Hospital Fund of New York is attempting to raise $2,383,887 for their voluntary hospital members. But that isn't the total deficit, not by a long shot. The total deficit amounts to $4,500,000. They didn't have the nerve to try for any such sum as that. Their campaign workers would become discouraged at the start, it was felt. And the hospital situation in New York isn't too different from what it is in Connecticut; Kankakee, Illinois; or Oshkosh, Wisconsin.

What's the answer? Are we to turn our hospitals over to federal, state, county or city government, or are we to persevere in the voluntary tradition which we acknowledge has given this country the highest type of health service that is to be found anywhere in the world. The answer is in the hands of you trustees, the faith that you possess, the true knowledge of the situation that you acquire, the leadership that is inherent in you and which you must exercise today—now, and not at some future time.

Hospital and health service, the greatest public utility in this country, remains singularly lacking in interpretation, support and leadership. It lacks the elements of wise counsel, imagination and intelligent overall planning that are essential to provide every man, woman and child with the highest type of health care at the lowest possible cost.

What leadership has exerted itself in hospital activities in the past has been measured too often by one individual's contributions to a single hospital, contributions made in the form of time, money, sometimes of both. Hospitals have been a medium for philanthropy, and their sponsors have been philanthropists first, and leaders of health and social movements second. These men for the most part have thought and planned in terms of a single institution motivated by individual interests, rather than in terms of community or national health and medical care.

In fairness, it should be explained that this is predicated on the days before hospitals and public

Presented before Connecticut Hospital Association, New Haven, December 4, 1947

health played such an important part in community planning as they do today. Each unit of service was then judged by its individual accomplishments and prestige, rather than by the value of its contribution to an overall pattern. Furthermore, there was little knowledge on the part of the average trustee of his precise functions and the complexities of hospital operation.

We now recognize that "to sit" on the board of a hospital no longer describes adequately the obligations of the trustee. If this individual has assumed his hospital obligations sitting down rather than standing up, it is because he has never been informed what he should stand up to. To this serious oversight may be attributed the lack of any overall hospital system in the country today. It is only within the past few years that trustees have begun to learn.

Where the desire for knowledge exists, ignorance can easily be overcome. The question is, have we that desire, what can be done to develop it, also what constitutes true leadership in hospital affairs?

To promote a desire for leadership we must make the cause and its end results worthy of the efforts expended. There must be definite challenge.

If this be true, there should be no difficulty in attracting competent leadership to the hospital field. What better end results could we have to fight for than the health of the nation, conquering the many dread diseases to which men, women and children are falling victims daily?

Hospitals, moreover, constitute big business. They represent a total purchasing volume of more than a billion dollars annually. They feed one and a half million patients and a million employees every day at standards comparable with a good hotel. Their raw food bills alone total nearly one half billion dollars a year. They operate laundries comparable in size with commercial laundries in their communities. The capital investment in their properties reaches staggering proportions, and it is estimated that the accumulated need for new and replacement hospital facilities at this time totals almost four and a half billion dollars. It has been said that hospitals employ as many workers as coal mining, printing and publishing, or the public utilities. Who will say that this is not the language of big business and that as custodians for the vast sums held in trust we haven't need of leadership?

Upon the quality of hospital leadership exercised will depend the quality of hospital and medical care that the American public may expect. It is a q tion whether such leadership will come volunta from the ranks of these public spirited citizens w without thought of personal advancement, are s ing to perpetuate a hospital system free from g ernment control, or whether our hospital poli shall be established in Washington.

We have every reason to look for such lea ship among the ranks of public servants who n are serving on voluntary hospital boards throu out the country. Their knowledge of certain b problems of hospital care should enable them understand better the broader issues which must met. This need not necessarily debar others, h ever, who through unselfish interest in public aff may possess the vision and the competency to s in and provide direction.

Hospital leadership must obviously start at t community level and from that point develop state and national importance. It will manifest its first through hospital and public health planni for a specific community, assuring a definite patte by which every citizen of that community m expect adequate and proper health care.

We see what proper leadership in this directi has accomplished already, and can accompl through regionalization of hospital services. In c tain communities a group of formerly unrelated a poorly equipped hospitals and now welded into strong chain of modern medical and hospital uni supplementing one another successfully in th various services, and, in addition, providing educ tional opportunities for doctors, nurses and oth professional workers.

We see the same trend toward new hospital thin ing and planning in the recent two-year stu undertaken by the Commission on Hospital Ca It was the function of this group to make a co prehensive study of hospital and health care fac ities throughout the United States for the purpo of recommending a plan for the development of coordinated national hospital service.

We see the same trend in hospital planning f large metropolitan centers, exemplified in extensi studies made by the Planning Committee of t Hospital Council of Greater New York in presen ing a pattern to assure every section of that cit adequate hospital care without duplication of ser ices. The time has passed when hospitals, like Tops merely grew. Today they grow to an amazin

gree, but within the confines of overall planning. Such examples of intelligent planning are sufficient to indicate what sound leadership can accomplish in creating a pattern. Granted that we have the pattern, however, we still need leadership in building to that pattern.

It has already been pointed out that hospital leadership may well start at the community level. There can be no better medium for studying and organizing hospital work on a community basis than through the formation of local hospital councils. Such groups, comprising presidents of boards, administrators, and such public health officials as seems expedient, meeting at regular intervals to discuss mutual problems, are definitely steps in the right direction. But they must have leaders.

Assuming that the president of a hospital through attendance at hospital council meetings becomes cognizant of the various problems that present themselves, the question remains how this knowledge may be shared by the rest of the board. One suggestion is to hold community or regional trustee institutes with programs carefully selected to bring the average board member up to date on hospital developments, to broaden his knowledge, and to encourage him to play a more active part in hospital affairs. How else can we hope to develop potential leaders?

From local activities it is not a great step to state activities. Here administrators working in conjunction with trustees will form a team that is destined to shape the future of our hospitals.

For years hospital administrators (as we all know) have been meeting in various local and national groups to discuss their problems. Some of these problems are administrative and within their province. Others, of broader implication, involving health and medical policies, are beyond their jurisdiction. Yet seldom, if ever, is a trustee present to acquaint himself with these current issues, or to participate in any discussion. All the administrator has been able to do was to go back, report and attempt to interpret. But the indirect method is never as effective as the direct.

What is needed today is concerted action, teamwork on the part of all hospital people—laymen and professionals. The patient, which is your voluntary hospital, is too critically ill to be entrusted to the care of one type of professional alone; it has need of the benefits of group practice, so to speak, the best knowledge, experience and planning of the entire community or region to establish a diagnosis and to determine a proper course of treatment.

It is for such purpose that we are assembled here tonight—to promote better teamwork among hospital trustees and administrators throughout the State of Connecticut, to encourage you trustees to follow more closely the activities of your state and local hospital associations, because by so doing, you will learn and can contribute leadership.

Action taken a few months ago by the New Jersey State Hospital Association in electing a hospital trustee to its vice-presidency would seem to be significant. How else can we develop public interest and support for our hospitals than by working closely together, professional hospital people and representatives of the public?

Much emphasis has been placed on higher standards of hospital administration. But what can the ablest administrator do without the intelligent support of his board? It is the trustee who establishes policies; the administrator is there to carry them out. The hospital trustee who believes that through paying a few thousand dollars more for an administrator he will find the answer to his problems and thus be absolved of his responsibilities is only kidding himself. We have need of higher standards of hospital trusteeship as well, to form a team that will go out and get into action, not remain somnolent in the comfortable chairs that some board rooms provide.

What can leadership accomplish? Among other things we have definite need for leadership in influencing local and national legislation affecting our hospitals. Where the voice of the trustee should count for much, it seldom if ever is heard, unless particularly pressure is brought to bear upon him to express his objection or approval. Too frequently, unfavorable, dangerous laws even are passed without the trustees' knowledge. Challenges to the voluntary hospital system of this country are being made almost daily which require the best brains and talents possible. Many hospital boards have an abundance of both; they need only be made available.

Fund-raising projects provide additional opportunities for the trustee to reveal his potentialities as a leader. The success or the failure of such development programs rest to large extent, it has been proved, upon the leadership exerted by citizens of the community, whether or not they happen to be trustees. The knowledge gained through rehearsing

the hospital story and relating it to others provides excellent training for leadship. The individual thus becomes virtually a salesman for the hospital. And our hospitals need salesmen.

Having developed hospital interest and leadership starting on a community level to and through a state level, we now proceed to the final step. Reference has previously been made to the tremendous contribution made by the Commission on Hospital Care in which a group of professional workers, prominent laymen, and social agency workers, with the assistance of hospital studies provided by the various states, formulated a pattern for a coordinated national hospital service. Having been shown the way, the present need is for suitable leadership to direct us along paths that will lead to the desired goal. It is vital that we not overlook the broad picture of hospital service on a national basis.

Through the sponsorship of the American Hospital Association various projects have been inaugurated looking toward the advancement of hospital services in this country. It is to be hoped that greater opportunity for participation in its affairs will be provided for trustees and other public health and social agency workers to assure broader interpretation of hospital policies, and closer integration of hospital services with other public health projects. If the pattern, as formulated by the Commission on Hospital Care, appears sound and logical, why not the appointment of some continuing body, with the same diversification of interests represented?

Similarly, why should not the names of certain hospital trustees appear on various committees of the American Hospital Association? Why should such names not appear among its officers and directors even? If we would be assured of true leadership we have need to nourish it, to give it a chance to grow.

To accomplish our aims it is necessary to divert the interest and attention of laymen from individual planning and thought, to central planning a thought, to broaden their horizon to include t one type of hospital alone, but hospitals genera to cause them to make personal sacrifices if nec sary to realize an all embracive hospital progr that will serve the many, rather than the few.

And what are or should be our aims? It seems me that Bernard M. Baruch answered this questi effectively when he said recently: "More and bet doctors—in more places; an immediate survey modernize medical education, with greater empha on chronic and degenerative diseases, mental hygie and preventive medicine; more hospitals, more eve ly spread through the country; less specialists, mo general practitioners; reorganization of medi practice, stressing group medicine; increased me cal research; greatly expanded physical and men rehabilitation; a vigorous preventive medical pr gram, reaching children, above all; creative of non political 'watchdog' committee to safegua programs in medical care for veterans; increas numbers of well trained nurses and technician adequate dental care; and a stabilizing economy inflation will make worthless any health progra or anything else."

And how can this best be accomplished? Throug proper leadership, using existing voluntary channe with such help as may be necessary from federa state, county and city government. For no long can our voluntary institutions furnish service f less than operating cost.

Our hospitals today form the basis of communit health programs which are rapidly taking form What threatens to retard their development is lac of leadership. That leadership is there. What it nee is stimulation, encouragement, recognition of th importance of hospitals in the life and welfare o the nation. Also the fact that hospitals do constitut big business.

THE USE OF THE VAGINAL SMEAR IN THE DIAGNOSIS OF CANCER

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It is almost twenty years since Papanicolaou[1] first described his technique of cytological examination for malignant disease. The idea of searching for malignant cells in body fluids was not new. Sporadic reports had appeared in the past but the results were never encouraging. Papanicolaou's contribution was outstanding, in that his observations were based on a thorough knowledge of the normal cytological picture. His complete familiarity with the normal range of variation permitted him to establish criteria of abnormality for the epithelial cells encountered in the vaginal fluid. When it was noted that abnormal cells were found only in the presence of malignant disease of the genital tract, the method was applied to diagnostic purposes.

Many investigators[2,3] have now confirmed Papanicolaou's work. Modifications have been suggested in the method of collection and of preparation of the material. Ayre[4] prefers to scrape the cells directly from the region of the cervical os. Hunter[5] prepares several specimens from each patient, including smears and blocks of secretion which are fixed and cut in orthodox pathological fashion. At the Vincent Memorial Laboratory of the Massachusetts General Hospital we have always emphasized simplicity of technique. It has been our hope that this factor, more than any other, would find a place for the method in the office practice of any physician who desired to use it. It also lends itself more readily to use for screening purposes in the cancer detection clinic. We follow the procedure outlined by Papanicolaou[6] of direct vaginal aspiration with a rubber suction bulb attached to a length of dry glass tubing. Effective suction can be exerted if the tip of the pipette has been flamed down to a lumen of capillary size. Material is expelled on a glass slide, spread thin with the tip of the pipette, and placed at once in a fixative solution of equal parts 95 per cent alcohol and ether. After fixation it is stained, also by the method of Papanicolaou. Any factor that will obscure cellular details should be avoided. Patients are requested not to douche beforehand. Excessive discharge, particularly bloody discharge, renders interpretation more difficult. The smears are taken before pelvic examination is carried out, since lubricant is also undesirable in the secretions. Drying is avoided by placing the slide in fixative fluid without delay.

Interpretation in our laboratory has been carried out by Ruth Graham and the technicians she has trained. The characteristics of abnormal cells[6,2] are hyperchromatism of their nuclei, wide variations in nuclear size, loss of the normal nuclear-cytoplasmic ratio, and disappearance of cellular borders when they occur in groups. Bizarre cells are seen, usually in the more differentiated epidermoid tumors. The method has found ready application in the study of other body fluids[7] and stomach, pulmonary, and urinary tract lesions have so been detected. Radiation reaction can be studied[8] and its importance lies in the fact that this application of the technique may be of prognostic value in the treatment of carcinoma of the cervix.

The statistical summary of our experience with the method is shown in Table 1.

TABLE 1

Cases without malignant disease	3258	
First smear reported positive		54 or 1.6 per cent
Cases with malignant disease	372	
First smear reported negative		48 or 12.9 per cent
Total cases	3630	

Further study of the cases with proved malignant disease (Table 2) reveals that the error is much higher in endometrial lesions. This might be expected since the chance of cells from such tumors being present in the vagina at any given time must be less than is the case with cervical cancers.

Presented as part of a panel discussion at the 22nd Clinical Congress of the Connecicut State Medical Society, New Haven, September 17, 1947

Table 2

Cancer of the cervix	275
Smear called negative	28 or 10.1 per cent
Cancer of the endometrium	97
Smear called negative	20 or 20.6 per cent

All smears proved to be erroneous have been carefully reviewed. Occasionally this review discovers characteristic cells in a smear previously called negative. Often the smear is still negative and it must be assumed that no abnormal cells happened to be present in that specimen.

The false positive smears from patients without demonstrable cancer form an interesting group. Some have been obvious errors in interpretation, made in the early days of the series. Others, however, are still considered positive after review. Careful study by serial section has been made on the uterus in several such instances and exceedingly small cancers invisible to the naked eye have been demonstrated.

The value of the method in diagnosis cannot be judged on statistical grounds alone, as Gates and Warren[9] have pointed out. It must not be supposed that it can ever replace the biopsy, or render unnecessary a careful physical examination of the patient. Rather it should take its place with these procedures as another weapon in our constant battle against malignant disease. Graham and Sturgis[10] have shown that the combined use of biopsy and smear demonstrated cancer of the cervix in approximately 98 per cent of their cases on the first test, whereas each method alone found 90 per cent of them. The smear is useful because it can detect exceedingly small lesions, often before they demonstrate histological invasion. It is useful because it can single out for immediate further investigation, patients that might otherwise have been assigned to a period of further observation.

CONCLUSIONS

1. The diagnosis of cancer of the uterus can b made with a high percentage of accuracy by th vaginal smear method, as described by Papanicolaou

2. Early cases of cancer and pre-invasive car cinoma can be detected by this method.

3. Careful physical examination and biopsy mus still be done, if we wish to make the most intelligen use of this technique.

BIBLIOGRAPHY

1. Papanicolaou, G. N.: New Cancer Diagnosis, Proceeding of the Third Race Betterment Conference, Battle Creek Michigan, 1928.

2. Meigs, J. V., Graham, R. M., Fremont-Smith, M., Kap nick, I., and Rawson, R.: Value of the Vaginal Smear i Diagnosis of Uterine Cancer. Surg., Gynec.. and Obst 77:449-461, 1943

3. Ayre, J. E.: Vaginal Cell Examination as Routine i Diagnosis: Study of Vaginal and Cervical Cytology as Re lated to Abnormal Growths, South. Med. J.. 39:847-852 1946.

4. Ayre, J. C.: Selective Cytology Smear for Diagnosis o Cancer, Am. J. Obst. and Gynec.. 53:609-617. 1947, (April)

5. Hunter, W. C., and Richardson. H. L.: Cytologic Rec ognition of Cancer in Exfoliated Material from Variou Sources: Useful Modifications of the Papanicolaou Tech nique, Surg., Gynec., and Obst., 85:275-280, 1947.

6. Papanicolaou, G. N., and Traut, H. F.: Diagnosis o Uterine Cancer by the Vaginal Smear, 47 pp., New York Commonwealth Fund, 1943.

7. Papanicolaou, G. N.: Diagnostic Value of Exfoliated Cells from Cancerous Tissues, J.A.M.A., 131:372-378, 1946.

8. Graham, R.: Effect of Radiation on Vaginal Cells in Cervical Carcinoma. I. Description of Cellular Changes. II Prognostic Significance, Surg., Gynec. and Obst., 84:153-173, 1947.

9. Gates, O., and Warren, S.: A Handbook for the Diagnosis of Cancer of the Uterus by the Use of Vaginal Smears. Cambridge, Mass., Harvard University Press, 1947.

10. Graham, R. M., Sturgis, S. H. and McGraw, J.: A Comparison of the Accuracy in Diagnosis of the Vaginal Smear and Biopsy in Carcinoma of the Cervix, American Journal of Obst. and Gyn., 55:303-307, 1948.

CORONARY ARTERY DISEASE IN WOMEN UNDER THE AGE OF THIRTY
(A report of two cases)

PETER J. STEINCROHN, M.D., *Hartford*

Disease is very old and nothing about it has changed. It is we who change as we learn to recognize what was formerly imperceptible" (J. M. Charcot—1857.)

AGE is the great red herring that nature draws across our path as we pursue the proper diagnosis of coronary artery disease. For example, 10 or 15 years ago physicians proclaimed that this entity was uncommon under 50. Gradually that age barrier has been lowered so that today we recognize that it is not uncommon between 40 and 50; not rare between 35 and 40; and not unreported in the twenties and teens.

Physicians acknowledge that the incidence of coronary disease in women is less than in males (a ratio of 1 to 4 or 5 is reasonable). However, we must admit that we overlook many diagnoses of coronary disease in the female simply because we think "she is too young to have it." Such reasoning is one of the greatest single deterrants to the proper diagnosis.

Unfortunately there is much in the literature which reinforces this widespread opinion that coronary disease in young women is not a pressing problem because it rarely, if ever, exists.

Underdahl and Smith,[1] concerned with the relative rarity of coronary artery disease in women under 40 years of age, undertook to study its prevalence in this age group. They examined the records of 95,000 women under the age of 40 who were seen at the clinic between 1935-1945. They found 27 patients who had coronary disease (a ratio of one case to 3,500 patients). Of the 27 patients, only one was under the age of 35. She was 30 years old. The ages of the remaining 26 patients were between 35 and 39.

They concluded: "The results of this study confirm our previous impression that coronary disease under the age of 40 is very rare in women. From this study it would appear that coronary disease in women under the age of 40 is practically non existent except in association with either obesity, hypertension or hyperlipemia or some combination of these conditions." Here again age incidence comes to the fore as presumably of utmost importance in making a differential diagnosis.

Levy and Boas[2] reported a study of 169 women who had coronary disease. They concluded that coronary disease occurs infrequently among women under age 50, unless it is associated with hypertension or diabetes mellitus.

Baker and Willius[3] studied 100 consecutive cases of coronary thrombosis in women. Only 8 patients were less than 50. The youngest patient was 30.

On the other hand, there is the study of Master, Dack and Jaffe[4] who collected case reports, both clinical and based on autopsy, in which 115 attacks of coronary occlusion occurred before age 41: "The patients included an infant seven months old, seven boys and girls aged ten-twenty years, eight men and women aged twenty-one to thirty, and ninety-nine patients thirty-one to forty."

One must admit that in young persons it is sufficiently prevalent to challenge the wisdom of our present consideration of age as a diagnostic factor. The report of the following unusual case hopes to discourage this attitude. The author failed to make the diagnosis of coronary artery disease in this 28 year old female because *at the time* he also thought that "she was too young to have it."

CASE REPORTS

Case 1. B. L., a 28 year old, full term primagravida was admitted to the St. Francis Hospital, Hartford, at 3:10 A. M. on October 20, 1943 under the care of her obstetrician (Dr. J. W.). Her past history was negative except for measles and scarlet fever. Her father and mother were living and well. One sister was living and well. Her present illness was uneventful except for occasional vomiting and edema of the legs which symptoms were attributed to her pregnancy.

The first stage of labor began at 3:10 A. M. on October 20, 1943. Contractions were weak, irregular and infrequent. Spontaneous rupture of the membranes occurred at 6:45 A. M.

The second stage began at 7:00 P. M. the same day. Contractions were strong, regular and frequent. General condition of the mother during labor was good. Medication during labor was seconal and scopalamine. Delivery was by low forceps. Episiotomy was performed. Ether was given for delivery and repair. Female child in good condition at birth.

According to the nurses' notes the obstetrician was called at 12:20 A. M. on October 21, 1947 (about 1½ hours after delivery). The patient had become cyanotic, coughed considerably bringing up blood tinged sputum. Her respirations were rapid, she was restless, pulse 140-160, B.P. 88/52. Oxygen, coramine, 5 per cent glucose were administered. She was bronchoscoped at 2:00 A. M. with aspiration of bronchial tree. Her B.P. was 100/62 at 6:00 A. M. She slept in naps to 7:00 A. M. At 8:00 A. M. Temp. 101[4]—P. 148—R. 44, patient still coughing and expectorating bloody fluid. At 11:00 A. M.—3:00 P. M. Patient very restless and cyanotic. Complained of severe pain along left side on moving. At 3:00 P. M. Temp. 99[2]—P. 130—R. 32.

The author first saw the patient at 9:15 P. M. on October 21, 1943. She was coughing, expectorating blood-streaked sputum. P. 140—T. 101—R. 44.

Excerpt from note in consultation: History of sudden onset of dyspnoea,[4] cyanosis, rapid pulse a few hours after normal delivery. Impression:—suddenness of onset suggests pulmonary embolism with large infarct rather than pneumonia. (Although coronary failure was not considered as a major factor, an electrocardiogram was ordered as a routine procedure. Unfortunately it was not obtained in time.)

She expired at 8:10 on October 22, just 53 hours after admission. *Report of portable x-ray:* Bilateral haziness of the pulmonary fields, more marked on the right, with some mottling throughout the right lung field. The trachea is not retracted and the heart is not displaced.

Impression:

(1) Bilateral virus pneumonia.

(2) Bilateral edema.

The post mortem report by Dr. Louis Hastings, in summary, reads gross impression, atherosclerosis of coronary arteries, coronary insufficiency, pulmonary edema with early focal pneumonia, infarct of spleen. The atheromatous changes are particularly marked throughout the anterior descending artery with lumen narrowed to a barely visible slit in many places. Microscopic, sections completely confirm the gross findings without additional information. The coronary vessels reveal typical atherosclerosis with marked intimal proliferation and lipoid deposits. The myocardium is devoid of scars or other pathology. The abdominal portion of the aorta presents well defined and extensive pure atheroma of intimal surface. The diameter of abdominal aorta is small, not admitting the little finger. The lungs present marked pulmonary edema with early focal pneumonitis.

COMMENT

It is interesting to refer to a conclusion in Averbuck's[5] excellent report in which he states: "When the clinical picture suggesting coronary artery thrombosis occurs in a female patient who has neither arterial hypertension or diabetes, a p- monary embolus should be suspected."

In this case, there was no history of diabetes hypertension. In view of the pathological findi perhaps it might be better in the future also suspect the presence of coronary artery disease.

A search of the literature reveals a few cases t bear some similarity to the one under discussion.

May[6] describes a woman of 20 years who h electrocardiographic evidence of a basal infarct. R and Frankenthal[7] report coronary thrombosis co plicating pregnancy in a woman of 45 years, w marked hypertension and congestive failure.

White, Glendy and Gustafson[8] report a ea which most resembles the one we are discussi (except for the outcome): "A woman aged twent two, has been observed with clinical and electr cardiographic evidence of acute myocardial infar tion, undoubtedly the result of coronary thrombo (coronary embolism is a very remote possibility In the case here reported the coronary thrombo complicated pregnancy in the second month wi no harmful effect on the normal course of the pre nancy, childbirth or puerperium."

In our case, a previously asymptomless, thoug badly damaged circulatory system undoubted collapsed because of the added burden of childbirt Goodson and Willius[9] reported a patient of 22 yea who died in her third month of pregnancy 16 hou after a fall. Postmortem examination revealed a acute infarct of the posterior wall of the rig ventricle and likewise a linear infarct of the centr portion of the interventricular septum, extendin from base to apex. The authors wondered if cor nary thrombosis occurred as a consequence of th head injury resulting in shock and unconsciousnes Knowaler and Sears[10] state that coronary athero sclerosis may occur in the young if the tendene toward disturbed cholesterol metabolism is inherit ed. (One wonders, in the absence of a family histor of coronary disease, if the cholesterol in our patien was elevated.) In their experience, "atherosclerosi did not sufficiently affect the size of the lumen o the aorta." The great degree of involvement in ou case is therefore interesting.

A review of all the factors involved in this cas emphasizes the need for repeating that coronary artery disease should be considered in the differen tial diagnosis whenever a young woman, pregnan or otherwise, exhibits the signs and symptoms o such circulatory insufficiency.

ase 2. Mrs. G. P. H., a white woman 25 years of age
ca e to my office for examination in October 1947. She
ha been well until 1½ years previously when she began
to eel tired, listless and nervous. Complained of dizzy and
"a gone" feelings which came usually on getting into bed.
T se queer, weak sensations came like a wave of sinking
or aint feelings and lasted only a few seconds. For the past
fe months she has had a heaviness in her chest "as if
sc ebody was sitting on it." She had no shortness of breath
or palpitation but stated that the chest discomfort was
ag ravated by such exertion as driving her car or walking.
Sh said that her chest has felt worse during the cold
w ther. At no time has she had to stop walking, but has
h to slow up. She said that she was "quite tired of having
th pain" and that "when it is bad it goes down into both
ar s, especially down the right shoulder and forearm."

n ending her description of symptoms this 25 year old
gi said: "I must have been born at 25 and am now 50
y rs old." (In view of the subsequent findings in this
p ent this was an excellent lay estimate of the underlying
p nology.)

At no time had this patient experienced any anxiety about
h heart. She came for examination because she was "tired
o taking sedatives and vitamins for her nervousness and
r down condition" without being helped.

Physical examination: The patient 65 inches in height,
weighed 123 pounds (no recent weight loss). Her urine
s negative. B. P. 110/80; Fluoroscopic examination was
gative and there was no indication of heart disease or
er affection on physical examination.

Laboratory and other investigations: Electrocardiogram
en on October 15, 1947 furnished the first evidence of
cause of her complaints. T1 was low in amplitude. T2
s inverted; T3 was inverted with no Q wave. Chest leads
re not obtained. Tracing was repeated on November 3,
47 at which time T1 was still low amplitude and T2 was
w iso-electric. Chest leads offered no further informa-
n. Rhythm, Rate PR and QRS intervals were normal.

Basal Metabolic Rate was –10 per cent.

R. B. C. 4,500,000; Hb. 15.1 gms. (88 per cent.)

White blood cell count 8,200 with normal differential.

rum cholesterol was 308 mgm. per 100cc (normal for
e method 160-220).

Blood sedimentation rate (Westergren) Total in one
ur—4 mm.

A tentative diagnosis of coronary artery disease was made
t patient was admitted two days later to the Hartford
ospital for study.

Electrocardiographic report of November 17, 1947: Rate
. Rhythm normal. Pr. .17 seconds. RT in leads 1 and 2
ows minimal downward bowing. T2 diphasic. T3 and
-CF3 negative.

Findings: The gram is abnormal. The changes, however,
e not in themselves diagnostic. Further interpretation is
mited because of absence of clinical information (Dr.
. H. T.).

Blood cholesterol was 239 mgm. per 100cc.

Basal metabolism—6 per cent; W.B.C. 6,800; blood sugar
lerance normal.

B. S. R. was 2 mm. per hour. Gall bladder x-ray was
ormal.

Heart and lung plates normal.

COMMENT

After an evaluation of the above data, a diagnosis of coronary artery disease with angina pectoris was made in this patient. However, other possibilities were first ruled out.

For example, Levy and Boas[2] stated: "Mistaken diagnoses of coronary artery disease in women are common because of the erroneous interpretation of symptoms, such as precordial pain with or without radiation to the left arm, a sense of choking and a fear of death. Such symptoms are common in the absence of organic heart disease."

It is probably true that physicians are not as "coronary conscious" in diagnosis in women under 30 years as they might be. Therefore it may be expected that many such conditions are overlooked for this reason.

The possibility of a rheumatic carditis was considered as a possible cause of the symptoms in this case, but was ruled out in the absence of murmurs, cardiac enlargement, abnormal sedimentation and white blood counts.

Repeated basal metabolisms eliminated myxedema as a cause of the discomforts. Negative gall bladder x-ray cleared that organ as a source of referred pains.

Anxiety neurosis and effort syndrome were considered and discarded as a diagnosis. White[11] and others studied the electrocardiogram in such cases and came to the conclusion that these conditions did not produce actual changes in tracings. Weinstein[12] in reporting 10 cases in the younger age group found that "blood cholesterol figures were within normal limits or only slightly elevated. Blood sugars were normal, basal metabolic rates were within normal limits."

Repeated blood cholesterols in this patient were higher than normal.

The changing electrocardiographic patterns are interesting in this case in the absence of altered physical findings, blood sedimentation rates and white blood counts. The absence of a typical electrocardiographic pattern indicating infarction in the present or in the past, may raise some doubt about the unquestionable correctness of the diagnosis. I have tried to demonstrate that no other diagnosis is so equally tenable in this case as that of coronary artery disease.

SUMMARY

Coronary artery disease in young women is often overlooked because we allow the age of the patient to influence our diagnosis.

Two case reports of women (ages 25 and 28 years) with coronary artery disease have been presented. They emphasize the need for careful evaluation of all the well known diagnostic criteria; and suggest the advisability of relegating age (as such) to a position of minor importance in our diagnostic considerations of this disease.

BIBLIOGRAPHY

1. Underdahl, Laurentius O. and Smith, Harry L.: Coronary artery disease in women under the age of forty. Proceedings of the staff meetings, Mayo Clinic. Vol. 22, No. 21:479-482 (Oct. 15) 1947.

2. Levy, Hyman and Boas, E. P.: Coronary artery disease in women. J.A.M.A. 107:97 (July 11) 1936.

3. Baker, T. W. and Willius, F. A.: Coronary thrombosis among women. Am. J. M. Sc. 196:815-818 (Dec.) 1938.

4. Master, A. M., Dack, S. and Jaffe, H. L.: Age, sex and hypertension in myocardial infarction due to coronary occlusion. Arch. Int. Med. 64:767-786 (Oct.) 1939.

5. Averbuck, S. H.: The differentiation of acute coron artery thrombosis from pulmonary embolization, Am. J. Sc. 187:391 (Mar.) 1934.

6. May, W. J.: Coronary infarction in young adults, African Med. Journal 10:763 (Nov. 28) 1936.

7. Reis, R. A. and Frankenthal, L. E., Jr.: Labor in cardiac patient, with a report of the occurence of coron occlusion in pregnancy and labor. Am. Jour. Obst. a Gyn. 29:44 (Jan.) 1935.

8. White, P. D., Glendy, R. E. and Gustafson, Paul: My cardial infarction complicating pregnancy in a you woman: J.A.M.A. 109:863-864 (Sept. 11) 1937.

9. Goodson, W. H. and Willius, F. A.: Coronary thro bosis among persons less than forty years of age. A stu of thirty cases. Minnesota Med. 22:291-293 (May) 1939.

10. Konwaler, B. E. and Sears, Thad.: Coronary occlusi in the young adult. Rocky Mountain Med. J. 38:800-8 (Oct.) 1941.

11. White, P. D., Cohen, Mandel E., and Chapman, W P.: The electrocardiogram in neurocirculatory asthen anxitety neurosis or effort syndrome. Am. Heart Jour 34: No. 3 Page 390 (Sept.) 1947.

12. Weinstein, Joseph: "Atypical" coronary disease young people. Annals Int. Med. 21:252-271 (Aug.) 1944.

PENICILLIN IN THE TREATMENT OF SYPHILIS

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LIKE many new therapeutic procedures, the penicillin treatment of syphilis is passing through the three phases of dubiety, hyperenthusiasm and reaction. Mahoney's original report[1] was greeted with some skepticism, but this promptly gave way to ardent enthuiasm. It is four years since penicillin was introduced into the treatment of syphilis, and the forces of reaction now are becoming apparent. You have heard and read reports of how good penicillin is in the treatment of syphilis. It is upon a somewhat more reactionary theme that I should like to speak today.

First, let us consider early syphilis, thinking in terms of what theoretically would be the *ideal* form of treatment. It would be, in my estimation, on which is: (1) completely effective, (2) devoid o toxicity; and (3) one which could be given with minimum of inconvenience both to the patient an to his physician. The ideal treatment might be single pill which would cure everyone withou harming anyone.

With such an ideal in mind, let us compar penicillin with metal chemotherapy. We should no lose sight of the fact that metal chemotherapy i effective. It requires approximately 1800 milligram of mapharsen to cure 95 per cent of patients witl early syphilis. The safety of this form of therapy is in direct proportion to the duration of the tim period over which treatment is given.[2] The 180 milligrams of mapharsen can be administered ove a period of one year with a low death rate; but a the treatment schedule is compressed into shorte and shorter periods of time, the toxicity rapidly

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increases. Administered over as short a period as five days (as by the "five day drip" method), the death rate approximates one in 200 patients treated.[3] Is metal chemotherapy readily administered? This also depends upon the period of time over which it is given. We have used a schedule of metal chemotherapy that involves injections of mapharsen three times a week and of bismuth once a week over a period of from ten to twelve weeks. With this chemotherapy, there have been few serious reactions and a death rate of approximately one in 4,000-5,000 patients treated. It is 95 per cent effective, but is it easy to give? Apparently not, since among the clinic clientele with which we deal, only about fifty per cent of those who undertake this course of treatment complete it. Metal chemotherapy, then, while being effective, involves an element of risk. If this risk is to be minimized, the treatment must be prolonged; and with protracted treatment schedules, the follow-up is poor.

How does penicillin measure up? Penicillin is safe. There are as yet no reported fatalities from penicillin therapy. There have been a few relatively minor reactions. Is it easy to give? Yes, it can be given with considerable ease and over a relatively short period of time. But is it effective? It appears to be "effective" in about 70 to 75 per cent of those to whom it is given. Therein seems to be the disadvantage of penicillin in syphilis—its relative lack of therapeutic effectiveness.

There are several additional considerations. Can the effectiveness of penicillin be increased by altering the time-dose relationships of the course of therapy? There are presently available two sources of data on this point, one from the Syphilis Study Section,[4] the other from the Rapid Treatment Centers operated by the United States Public Health Service.[5] Their data agree remarkably well. Analysing the most recent summaries of these two groups, one is impressed by the similarities rather than by the discrepancies. With almost every schedule of penicillin therapy thus far evaluated, there has been a failure rate of approximately 25 to 30 per cent at 20 months. It seems to make little difference whether one uses 1.2, 2.4, or 4.8 million units of penicillin. It seems to make little difference whether the interval between injections is two, three or six hours. It seems to make little difference whether the course of therapy is four, seven and one half, or fifteen days. It seems to make little difference whether aqueous penicillin or penicillin in oil and wax is given.

There seems to have evolved in this country a group of *penicillin apologists* who prefer to soft-pedal the lack of therapeutic effectiveness of penicillin. They seek to tell us that we are seeing more reinfections (this may be true to a certain extent). They tell us that it probably makes no difference whether patients with early syphilis remain seropositive for one year or even two years. Perhaps it doesn't, but if it means the same thing as it did in the days of metal chemotherapy, it means that the patient has not been "cured." They stress that with penicillin, the majority of patients "complete the outlined course of treatment." They do complete it: i.e., all of the injections are given. But is it unreasonable to inquire, if one patient in four fails of cure from this treatment, whether anyone has "completed" it until the period of post-treatment observation has been sufficient to determine the outcome? Here again, when one attempts to follow a group of patients over any period of time, there is considerable difficulty in case-holding.

The conclusion seems inescapable that penicillin alone is not the final answer in the treatment of early syphilis. In what other infectious disease is the physician satisfied with a failure rate of from 25 to 30 per cent?

Can the effectiveness of penicillin be increased by combining it with arsenicals and/or bismuth? There is some experimental evidence to suggest that it can.[6] It must be remembered, however, that when even a few injections of arsenicals are given, there is introduced the risk of serious toxic reactions. The only discrepancy between the data from the Syphilis Study Section and that of the Rapid Treatment Centers is concerned with this point. The Rapid Treatment Center data suggests that the addition of mapharsen to penicillin schedules increases therapeutic effectiveness; the Syphilis Study Section data does not.

French syphilologists long have divided the therapy of early syphilis into two phases, a "treatment of attack" and a "treatment of consolidation." It was with something like this in mind that about two years ago we undertook a schedule of therapy which involves the use of penicillin in oil and beeswax given once a day for ten days. Concurrently with this, mapharsen is given every other day and bismuth, every three days. The course of treatment then is completed, consolidated if you will, by a course of nine additional weekly injections of bis-

muth. Some thirty patients already have been treated in this manner and thus far there have been no treatment failures. All of these patients have become seronegative by the sixth to the ninth month and thus far all have remained seronegative. None was seropositive at one year. Such schedules are promising.

There are certain situations in which penicillin is today the treatment of choice. Syphilis in pregnant women is best treated with penicillin. It can be given late in the course of pregnancy, and even in the presence of early syphilis in the mother the outcome for the child is favorable in a high percentage of cases.[7] Penicillin also is the treatment of choice in infantile congenital syphilis. There are serious technical difficulties in giving arsenicals to infants, and here the ease of administration of penicillin is a distinct advantage. Moreover, infants seem to do better than adults[8] for some reason which is not entirely apparent. Penicillin is also the treatment of choice in elderly people (for example, those with gummatous late syphilis), in whom one prefers to avoid strenuous and intensified courses of metal chemotherapy.

Let us now consider late syphilis. I do not wish to discuss in detail the use of penicillin in syphilis of the central nervous system, because I am sure that Dr. Adams, who is to speak next, will go into this subject in considerable detail. I should like to say, however, that in our experience the duration of the syphilitic infection is an important factor in the outcome, and that the degree of the meningeal reaction seems to be another important factor. The effect upon the cerebrospinal fluid is quite uniformly good. We have had excellent results in early asymptomatic neurosyphilis, but have thought it desirable to retreat with fever six of a group of eighty patients with late asymptomatic neurosyphilis after their spinal fluids again became "active." In parenchymatous and degenerative forms of neurosyphilis, such as general paresis[9] and tabes dorsalis,[10] there is, judging from our experience, no comparison between penicillin alone and malaria fever therapy with penicillin added. The combined therapy seems definitely superior.

As to other late manifestations of syphilis, there are reports of gummatous lesions healing under penicillin therapy. The same result can be accomplished with bismuth, and even with potassium iodide. No one has yet demonstrated satisfactorily that gummas heal more quickly with penicillin than they do with previously available forms of therap. There are at least two case reports of penicill. resistant gummas. The first was by Hill,[11] wh described a gumma of the center of the face th did not heal under penicillin therapy. We ha seen one similar case, a gumma of the penis, th healed with metal chemotherapy after being uni fluenced by penicillin.[12] Little can be said abo the use of penicillin in cardiovascular syphilis. Ma more years must elapse before there will be defin information of this subject. Nor is it possible speak definitively about penicillin in late late syphilis. There is, of course, no reason to expe that a patient who has received an "adequat amount of metal chemotherapy and whose bloo serologic test remains positive will be renderc seronegative by the administration of penicilli One of the most frequent problems referred to th consultant syphilologist is that of the patient wh has received a considerable amount of arsenicals an bismuth, but who continues to worry about persistently positive blood serologic test.

There are involved in the treatment of lat syphilis, and particularly late latent syphilis, a cer tain number of theoretic considerations which should like to discuss briefly. Against penicillin susceptible bacteria in vitro, penicillin is active whe these organisms are rapidly dividing, and almos completely inactive when these organisms are in resting phase.[13,14] Making two sizeable jumps fron bacteria in vitro to spirochetes in vivo, I should lik to suggest that there is at least some theoretic reaso to suspect that penicillin may not be as effective in late syphilis (and particularly late latent syphilis) a in the earlier phases of the disease.

Penicillin has been available for less than five years and syphilis is a chronic disease. It takes a long time for treatment failures in late syphilis to become apparent. In the past four years we have treated with penicillin approximately 500 patients with various late manifestations of the disease, and have seen,[15] and are seeing more frequently as time goes on, patients considered to be "treatment failures" from penicillin in late syphilis. We have seen the disease progress despite penicillin. We have seen skin gummas heal and periostitis develop. We have seen new lesions appear elsewhere in the body. The following case report is pertinent.

H. S., a 39 year old white man was first examined in November, 1945. He had gastrointestinal complaints that were of five years duration. He had consulted a physician

that time and on routine examination had been found have a positive serologic test for syphilis. He was given her irregularly a course of metal chemotherapy which not alleviate his symptoms. At the time of his original mination, he was found to have a positive spinal fluid th no clinical evidences of neurosyphilis, other than mini- l pupillary abnormalities. He was admitted to the hos- al, where a gastrointestinal series revealed the presence a chronic duodenal ulcer. A subtotal gastric resection as carried out and during the postoperative period, the tient was treated with penicillin. Six months later he re- rned for re-examination. The physical examination revealed change in the patient's condition. He returned again ghteen months after the course of penicillin, and stated this time that he felt that he was a "little bit out of ape," because he had been somewhat short of breath. Ex- mination at this time revealed a fully developed aortic gurgitation. The heart was slightly enlarged, and there as an early aortic diastolic murmur, together with all of e peripheral signs of widened pulse pressure. The spinal uid abnormalities had, nonetheless, improved.

In this case, there was no "therapeutic paradox." there had been, the cardiac lesion would have een obvious at six months. His disease had prog- essed despite eight million units of penicillin. This not an isolated case. We have seen others. Just ne other day, I saw a woman who had been treated ith penicillin for a nodular cutaneous syphilide ssociated with the rather unusual syphilitic burso- athy of Veneuil. The skin lesion and the bursitis ealed promptly following penicillin, but within wo months she had developed acute iritis. This cular lesion may not be due to syphilis, but there as never been any evidence of tuberculosis and here are no obvious foci of infection. The burden f proof rests with anyone who believes the lesion o be due to any cause other than syphilis.

I fully realize that I have presented the darker ide of penicillin therapy. This has been done delib- rately. Let there be no mistake—there is at the present time a definite place for penicillin in the treatment of syphilis. I suggest only that this place s not that of a panacea for all of the manifestations f this chronic and notoriously capricious infection.

BIBLIOGRAPHY

1. Mahoney, J. F., Arnold, R. C., and Harris, A.: Penicillin Treatment of Early Syphilis: Preliminary Report, Ven. Dis. Inform. 24:355, 1943.

2. Eagle, H., and Hogan, R. B.: Experimental Evaluation of Intensive Methods for Treatment of Early Syphilis: Clinical Implications, Ven. Dis. Inform. 24:159, 1943.

3. Reynolds, F. W., Mohr, C. F., and Moore, J. E.: Syphilis: A Review of the Recent Literature, Arch. Int. Med. 70:42, 1942.

4. Merrell, M.: Results of the Nation-Wide Study of Early Syphilis, Available in Mimeographed Form.

5. Cooperating Rapid Treatment Facilities and U. S. Public Health Service Venereal Disease Division: Rapid Treatment of Early Syphilis, Progress Report, December, 1946.

6. Eagle, H., Magnuson, H. J., and Fleischman, R.: The Synergistic Action of Penicillin and Mapharsen (Oxophenarsine Hydrochloride) in the Treatment of Experimental Syphilis, J. Ven. Dis. Inform. 27:3, 1946.

7. Goodwin, M. S., and Moore, J. E.: Penicillin in Prevention of Prenatal Syphilis, J.A.M.A., 130:688, 1946.

8. Platou, R. V., Hill, A. J., Jr., Ingraham, N. R., Goodwin, M. S., Wilkinson, E. E., Hansen, A. E., and Heyman, A.: Early Congenital Syphilis. Treatment of Two Hundred and Fifty-two Patients with Penicillin, J.A.M.A. 133:10, 1947.

9. Reynolds, F. W., Mohr, C. F., and Moore, J. E.: Penicillin in the Treatment of Neurosyphilis. II Dementia Paralytica, J.A.M.A. 131:1255, 1946.

10. Chesney, L. P., and Reynolds, F. W.: Penicillin in the Treatment of Neurosyphilis. III. Tabes Dorsalis, Arch. Neurol. & Psychiat. (In Press.)

11. Hill, W. R.: Problems Arising in the Treatment of Syphilis with Penicillin, New England J. Med. 235:919, 1946.

12. Hahn, R. D.: Late Gummatous Syphilis Resistant to Treatment with Penicillin: Case Report, Am. J. Syph., Gonor. & Ven. Dis. 31:542, 1947.

13. Hobby, G.; Meyer, K., and Chaffee, E.: Observations on the Mechanism of Action of Penicillin, Proc. Soc. Exper. Biol. & Med. 50:281, 1942.

14. Rantz, L. A., and Kirby, W. M. M.: Action of Penicillin on Staphylococcus in Vitro, J. Immunol. 48:335, 1944.

15. Reynolds, F. W.: Treatment Failures following the Use of Penicillin in Late Syphilis, Am. J. Syph., Gonor. & Ven. Dis. 32:233, 1948.

PSYCHONEUROSES: CLINICAL EVALUATION BY THE INTERNIST

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THE evaluation of a psychoneurosis includes (1) its recognition, and (2) an appraisal of the prognosis and effectiveness of possible therapy in the given case. Clinical recognition is important because sins of omission and commission can both lead to disaster. An example of the former is the battle-scarred abdomen upon which a series of unnecessary operations has been performed because the underlying psychoneurosis was overlooked. An equally embarrassing situation may arise when a psychoneurotic diagnosis is made without adequate positive findings.

Recently a prominent woman in late middle life was studied in detail by one of the leading internists of a mid Western city because of atypical pain in her upper abdomen. After repeated x-rays were negative the symptoms were attributed to a psychoneurosis and psychiatric therapy was instituted. During this treatment the patient became jaundiced and was transferred to the care of an Eastern internist who made the ultimately fatal diagnosis of carcinoma of the pancreas. During the terminal months of this woman's illness her cousin developed atypical pain in the upper abdomen. After detailed study by the Eastern internist, no organic cause was found and the symptoms were attributed to apprehension from contact with the fatally afflicted woman. During the inevitable psychiatric therapy jaundice appeared and surgical exploration in the mid Western city revealed carcinoma of the head of the pancreas. These errors were made by extremely competent internists because psychiatric diagnoses were made without positive findings.

To avoid the two types of error just enumerated it is essential that the patient be examined not only for the clinical abnormalities which point to organic disease but also for those which indicate psychoneurosis.

An appraisal of prognosis and effectiveness possible therapy in the individual cases is also nece sary if the physician is to separate wisely the cas which he can best treat himself from those whom should refer to a psychiatrist.

WHAT IS A PSYCHONEUROSIS?

The normal individual makes decisions readil suffers from neither overconscientiousness nor tot irresponsibility, enjoys association with other pe sons, has a reasonably accurate appraisal of himsel and derives satisfaction from such rhythmic bodil functions as eating, sleeping, exercise, defecatio urination, and sexual intercourse.

A psychoneurosis is a psychological reaction co ditioned by previous experiences which interfer with the efficiency of the mind in making decisio and in carrying out a normally productive lif Often one or more of the functions enumerate above are disturbed.

A psychoneurosis is usually based upon an u resolved conflict between an instinctive urge and social taboo. The conflict itself is not necessaril abnormal. A young boy standing in front of th window of a candy store has an urge to eat a lolly pop, but the consequences of breaking the glas stand between him and the consummation of h desire. He decides not to eat the lolly-pop. He thu solves the dilemma normally. A psychoneurotic bo might stand in front of the window with a brick i his hand unable to decide whether to throw th brick and take the consequences or to forego th lolly-pop. While holding the brick he would prob ably experience anxiety. All manner of instinctiv urges and all sorts of restraining social influence may make up a conflict.

The clinical features of a psychoneurosis depen to a large extent upon the physical or psychologica reaction set up in the body by the tension engen dered by the unresolved conflict. The prognosi depends to a certain extent upon these adjustment but to a greater extent upon the more deeply rooted

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factors which, by modifying instinctive drives and social taboos, make the resolution of the conflict difficult.

If the unresolved conflict maintains dominance for only a few moments the reaction is likely to be one of anxiety. If the unresolved conflict is handled by a specific psychological situation such as presence in a crowd, closed place, or on a high cliff, the reaction is known as phobic anxiety (or in Freudian terms, anxiety hysteria). In either instance the patient is acutely distressed with a feeling of uneasiness, weight on the chest, difficulty in breathing, palpitation, and sometimes faintness. At such a time he appears apprehensive. The pupils may be dilated, the mucous membranes dry, the palms and axillae moist, and there is often a coarse somatic tremor. The sensations and appearances of the individual conform to those characteristic of a normal state of fright.

The physician occasionally sees a typical anxiety attack in his office but more often hears one described in the history as a spell of palpitation, chest pain, faintness, or weakness. Most of his neurotic patients, however, give more confusing findings. There are several factors which may tend to complicate the picture.

(1) *Subjective reaction to basic anxiety.* People vary in the responses which come uppermost in the presence of anxiety. For some the somatic manifestations are predominant: e.g., excessive, vicarious or diminished appetite; insomnia; palpitation; dyspnea; or tremor. For others the difficulty may be an inability to concentrate, a feeling of blind frustration, an inexplicable sensation as if "something is going to happen," or a frank feeling of depression. One's subjective way of experiencing life's occurrences is constantly being altered. Just as people differ in the ways in which they experience measles, prostatic carcinoma, financial reverses, or grief, so too they vary in their responses to anxiety attacks.

(2) *Alteration of basic anxiety by chronicity.* When tension results from a dilemma which more or less constantly preys upon the mind, the clinical findings are less acute than those of the typical anxiety state. Chronic tension may appear as one of the following major psychosomatic states:

1. Tension headache.
2. Nervous indigestion.
3. Mucous colitis.
4. Neuro-circulatory asthenia.

Less commonly it takes the form of migraine headache, histamine headache, vasomotor rhinitis, burning tongue, irritable bladder, dysmenorrhea, or catarrhal endocervicitis. Likewise tension may play a role in aggravating bronchial asthma, urticaria, seborrheic dermatitis, pruritis ani, atopic dermatitis, peptic ulcer, ulcerative colitis, Raynaud's disease, etc. The recognition of most of these states is easy, and the importance of psychic factors in prolonging them is becoming widely recognized.

(3) *Alteration of basic anxiety by escape mechanisms.* The preceding discussion has had to do with the subjective and the somatic manifestations of anxiety as brought about by acute or chronic mental conflicts. The conflicts may be entirely situational or they may be based on deep rooted psychologic abnormalities but in either case they can produce acute anxiety or chronic tension which the subject may experience either as mental uneasiness or in terms of physical symptoms.

The clinical recognition of typical psychologic and physical manifestations would be comparatively easy were it not for man's being a rationalizing animal. In short, there are a number of psychologic escape mechanisms which assuage the discomfort of underlying conflict. By *rationalization* one convinces one's self that a purely selfish course is in the best interests of society. The "white man's burden" is an exemplification. By *projection* one places the responsibility for an intolerable situation upon the other fellow. By *regression* one resorts to an easy but immature pattern of activity in response to stress. Often a child who has learned to walk will revert to crawling if parental attention is monopolized by a younger brother. By *conversion* one develops a physical symptom (often a paralysis) which will preclude the performance of a duty about which there is a conflict. By *over-compensation* one assumes an air of self confidence and bustling activity which belies an underlying insecurity. Patients with peptic ulcer not infrequently follow this pattern. By *displacement*, *substitution* and *symbolization* rituals such as washing the hands may relieve anxiety caused by conflicts involving filth, or carefully evolved fixed ideas may obviate the necessity of ever looking squarely at the problem.

In general prognosis is best in cases where the components of the major conflicts are fairly simple and where the physical or psychologic manifestations are relatively direct. When the conflict is

dependent upon an abnormal biological urge, such as homosexuality, the resolution of the problem becomes more difficult. When elaborate rituals and fixed ideas have been built up, it may take very prolonged treatment before the patient can see the issues at all.

EXAMINATION

During the history and physical examination the physician should be on the alert for clues which give evidence of psychic tension as well as escape mechanisms by which it may have been dispelled.

Much information may be obtained during the first moment of the interview. If the patient is accompanied by a second person it almost invariably indicates a lack of normal independence (i.e., immaturity), one of the cardinal findings in psychoneuroses. For a man to have a wife older than he is may have similar meaning. A cold, clammy handshake usually points to predominance of the thoracicolumbar sympathetic system as the result of acute or chronic anxiety. In depressed states one may see a dejected facial expression with slow, faint speech and retarded movement. An overly prominent mustache usually indicates insecurity on the part of the wearer. A baby-doll face on a young woman suggests immaturity of the type seen with hysterical reactions. Fair complected women with widely dilated pupils often have anxiety. The slender, asthenic type of body build tends to go with schizoid withdrawn personalities. The rotund, pyknic physique (with round face, short neck, broad chest, round wrists, and spade hands) is often the hallmark of an outgoing individual who may be subject to manic-depressive mood swings. The psychopathic personality may swagger into the office with great confidence and make an initial good impression with his history of achievements and illustrious intimates.

The chief complaint may point quite directly to a psychogenic disorder if

(a) It is characteristic of one of the well recognized psychosomatic syndromes.

(b) It is atypical of any organic syndrome.

(c) It is unduly minimized or exaggerated in the telling.

(d) The patient is unable to "come to the point" and state his problem.

One gains considerable help from the manner in which the patient tells the history. Rapid fire sentences punctuated by deep respiratory sighs are almost pathognomonic of anxiety. Many hypochondriachal patients are unable to single out fr a maze of complaints the one which constitu the major problem; or if one symptom is remov the patient's attention becomes fixed upon anoth Actually the main problem is the underlying u easiness; the symptoms attract welcome sympat and afford an excuse for not making the effo demanded in a competitive society. Compulsi patients, on the other hand, may tell their histor in a very inflexible manner. They must often lay a considerable background before coming to t point. The depressed patient talks slowly and in weak voice. The anxious individual becomes ove excited by minor events. The schizophrenic m attach bizarre importance to wholly unintelligib occurrences. "There's a funny smell coming fro my left third toe which people notice across th street." The hysterical subject typically shows n anxiety but rather has a bland indifference to a obviously disabling symptom. Such a person ma say with a smile of satisfaction, "Why Doctor, haven't been able to straighten my knee for thr weeks."

A *vertical headache* is almost invariably hyster cal. Tension headaches are occipital with radiatio forward over the ears. They are often accompanie by tense, firm nuchal muscles. Sometimes the for ward radiations encircle the cranial vault like a ha band. This band-like headache may also be expe rienced in depressed states where it is sometime accompanied by a snapping sensation within th head.

Indigestion falls into several patterns. Perhap most common is the triology of belching, heartburn and sour eructations. So far as I know this is alway functional although it may accompany organi disease. The ulcer type of distress is functional i about 50 per cent of the cases. It cannot be differ entiated except radiographically. There are patient who complain of burning pain coming immediately after meals. This is functional, as is pain which occurs before breakfast.

Constipation, except for the occasional case due to intestinal obstruction, is a functional disorder. It is most commonly caused by the cathartic habit but sometimes is an expression of emotional tension. In such cases the movements are small in calibre, either mushy or pebbly, and there may be sensations of pressure, "gas," or cramps in the cecal and sigmoid regions. Beware of calling diarrhea psychogenic unless it develops gradually on an antecedent constipation.

Weakness is often a part of the neurocirculatory asthenia syndrome if maximal on prolonged standing and if accompanied by an unstable pulse rate and a small difference between systolic and diastolic blood pressure. There is often considerable lability of the autonomic nervous system in acute anxiety states and the somatic manifestations of tension such as headache, neurocirculatory asthenia, nervous indigestion, and mucous colitis. For this reason one should note particularly the degree of dilation of the pupils, sweating, goose flesh, and irregular flushing of the skin, especially about the head and neck. Nervous tachycardia and marked variations in the pulse rate are also pertinent. Coldness of the hands and feet point to dominance of the sympathetic division of the autonomic nervous system. Marked fluctuation in the systolic blood pressure is evidence of vasomotor instability. It may be of real importance in weakness or even syncope if the pressure is higher with the patient reclining than erect.

PROGNOSIS

The outlook in nervous patients is not dependent upon the severity of the symptoms but rather upon the nature of the psychologic abnormalities responsible for the basic conflicts, and the possibility of altering escape mechanisms which may have become established. The escape mechanisms, at least, have a part in determining the clinical manifestations; so the latter are helpful in determining prognosis.

States of anxiety and tension associated with exogenous circumstances have a good prognosis once a solution to the presenting problems is arrived at. So do hysterical symptoms if the precipitating problem is superficial and easy to comprehend. This is not to say that persons afflicted with these disorders are normal between attacks but rather that their inner tensions are minimal and only interfere with a reasonably happy and useful life at times of unusual stress or indecision. On the other hand phobic anxiety always represents a deeply buried conflict. For example a man standing on a high place may experience acute anxiety aroused by unconscious indecision over a self-destructive urge to jump. By steps designed to build up the general health and muscle tone of the patient the physician may reduce to a minimum the number of phobic attacks, but short of intensive and prolonged psychotherapy he cannot expect to alter the fundamental conflict. Obsessions and compulsions, tics, and rituals are even more stubborn. They seldom yield even after years of psychoanalysis. The hypochondriac is addicted to his medicine bottles and whining self-pity. He has regressed from outgoing human contacts to a narrow world of his own in which he is acutely miserable. He complains to the doctor of multiple vague aches and pains, most of which are exaggerations of normal bodily sensations. The doctor offers no hope of cure but with oft repeated reassurance can sometimes keep him on the job as a rather pathetic unit of human society.

The differentiation between neurotic (reactive) depressions and mild forms of the manic depressive state is extremely difficult. In either case the presenting symptoms may be those of anxiety or tension. Often these are insomnia, loss of appetite, fatigue, inability to concentrate, and feelings of unworthiness. Psychomotor retardation is more common with depressions of the manic depressive type. Agitation may be present with either. Depressions are important because of the risk of suicide. If this does not take place recovery is the rule even without specific psychotherapy. Depressions are frequently overlooked by practicing physicians who are unaware of the mild forms in which they often occur.

SUMMARY

Psychoneuroses are based upon conflicts between instinctive urges and the restraining forces of society. The strength of either may be modified by previous experiences. Conflicts produce acute anxiety or chronic tension either of which may manifest itself in somatic symptoms or be dispelled by psychological escape mechanisms. The escape mechanisms play a part in determining the clinical picture and in some instances (as with phobias, compulsions, and obsessions) convey information about prognosis. With presenting symptoms which represent direct expressions of anxiety or tension the prognosis is dependent upon the probability of solving the presenting conflicts. Where these result from exogenous, easily comprehended situations, the outlook is good; where they are the result of abnormal instincts or deeply rooted taboos the prospects are less hopeful.

CONCLUSIONS

Routine examination of the patient should include a search for symptoms and signs which point to the possibility of psychoneurosis. This diagnosis should never be made by exclusion. Psychoneurosis and other forms of illness often coexist. The prognosis is best in psychoneuroses based upon conflicts of an exogenous, easily understood nature and in those devoid of elaborate psychologic escape mechanisms.

INFECTIOUS MONONUCLEOSIS: A REPORT ON TWENTY-FOUR CASES

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Recently an editorial appeared in the *Journal of the American Medical Association* on increased incidence of infectious mononucleosis.[1] Infectious mononucleosis is a systemic infection of unknown etiology. It is usually a mild disease which runs a variable course, but it may have serious complications. The symptoms are varied and many, but there is a typical blood picture of relative or absolute lymphocytosis at some stage of the disease. The lymphocytes are of all types, large and small and there are "atypical lymphocytes" or mononuclear cells. In many cases the blood serum gives a positive heterophile agglutination test. This agglutinin may be present relatively early or late in the disease but some patients never develop a titer above normal, so that a positive test is not absolutely essential in the usual case for diagnosis, if the typical blood picture is present and the physical findings are significant.

The disease is more infectious and more prevalent at times than is realized. It is often overlooked because of its mild manifestations and its ability to simulate many other diseases. Since the disease to our knowledge is not reportable in Connecticut, there is no way of knowing the number of cases which occur annually.

It is the opinion of one of the authors (N. E. C.) that during the summer and fall of 1947 there was a mild epidemic of infectious mononucleosis in Bridgeport, Connecticut. During August, September and October 1947, one of the authors had the opportunity to see a number of cases. At this time of the year, most parents call a physician for minor indispositions in their children because of the fear of poliomyelitis.

Our interest was first aroused in this disease by the admission to Bridgeport Hospital on August 23, of G. S., a boy of eleven years. He was moderately ill and presented a clinical picture suggesting lymphatic leukemia. Following the admission of this patient, one of the authors saw several other children with similar complaints of lesser degree and routine blood smears were taken on all patients suspected having the disease. As a result of this procedu many cases were found.

By talking to several physicians we were able learn that there were many cases of upper respi tory infections, glandular disturbances and gastr intestinal complaints and "summer grippe" in t community. Most of these patients were said to ha recovered within a week or two and it is interesti to speculate on the number of these which mig have been found to have infectious mononucleos if blood studies had been done.

The following is a report of twenty-four cas which were seen from August 23 to October 1947. Most of the cases were private patients and few were patients of other physicians or patien admitted to the pediatric or medical services of t Bridgeport Hospital. All of the patients, with t exception of one negro girl, were white and the ag varied from three years to fifty years. The sym toms varied and were usually mild. Several patien were ambulatory throughout the course of t disease. One case suggested leukemia; one, scarl fever and one, leukemia and nephritis. Most patien had symptoms typical of an upper respiratory i fection with stuffy nose, slight sore throat, cou and adenitis. Some patients had nausea, vomiti and diarrhea with no visible or palpable glands. one boy, the typical lymphocytosis was obscur by a neutrophilic leucocytosis due to superimpos furunculosis. The lymphocytosis appeared after t furuncles were cleared up by using penicillin. A other youth was admitted to the hospital with a le lower lobe pneumonia, after he had been ill at hon for one week with mononucleosis. Most of the cas in adults were characterized by a mild upper respir tory infection, nausea and loose stools, profu sweating and prolonged asthenia. One woman ha complaints suggestive of undulant fever. Many the children complained of pain in back of the nec and lumbar region, but there was no rigidity examination.

PROCEDURE USED IN FINDING CASES

Whenever a patient in whom the disease was suspected was seen, a blood smear was taken. If this smear showed atypical lymphocytes or mononuclear cells, then a complete blood count was done and whenever feasible blood was taken for a heterophile agglutination test. The counts and smears were all prepared and examined by Margaret M. Flanagan, a technician at the Bridgeport Hospital.

The blood smears were then checked by Dr. Irving B. Akerson, the pathologist. Follow-up counts and heterophile agglutination tests were done whenever possible.

To aid in the recognition of these atypical lymphocytes, the descriptions given by Downey and McKinley[2] were used and also the descriptions and illustrations given by Wintrobe[3] and Krache.[4] The atypical lymphocytes are described as varying greatly in size and shape with a nucleus which may be oval, kidney shaped or slightly lobulated. The cytoplasm is non granular and vacuolated or foamy in appearance.

Heterophile agglutination tests were done at the Bridgeport Hospital and some were done by the laboratory of the Connecticut State Department of Health. The tests varied from negative to positive in dilutions up to 1:1024. The tests were done at various stages of the disease in different patients.

Following are reports on six cases which were admitted to the Bridgeport Hospital:

CASE NO. 1

G. S., male, age eleven, admitted to Bridgeport Hospital, August 23, 1947. He complained of slight cough and hoarseness and swelling of the neck. His illness started about August 1, with a "head cold," slight cough and "stuffy ears" which persisted for two weeks. On August 15 the patient was not improving and his temperature was 100.8 and did not respond to the usual remedies. On August 18, the temperature was 101.4 and the cervical glands were enlarged and slightly tender. With bed rest and aspirin, the patient improved slightly but the anterior and posterior cervical glands had enlarged tremendously, so that the entire neck appeared swollen and the spleen was palpable. A tentative diagnosis of "glandular fever" was made but on August 23 the patient was admitted to the hospital for complete blood studies. Examination on admission showed that the neck was visibly swollen due to the enlarged cervical glands. There were also glands in the axillae and inguinal regions and the spleen was palpable three fingers below the costal margin. The first complete blood count showed: Hgb. 11.3 grams: Rbc. 4,670,000: Wbc. 14,100: Polys. 16 per cent: Segs. 12 per cent: Bands. 4 per cent: Lymphocytes 80 per cent: Monocytes 4 per cent: "Blasts" were noted in the blood smear and these appeared like those seen in lymphatic leukemia. A peroxidose stain showed 23 per cent granular and 77 per cent non granular cells. All the lymphocytes were reported as atypical. Because of these findings and pending further laboratory work, the patient was started on penicillin. On August 26 the patient was improved and by August 27 the swelling of the neck had subsided rapidly. A heterophile agglutination test was positive in dilutions up to 1:64 and a blood culture was negative. August 26 the bleeding time was one minute and thirty seconds: venous coagulation time six to eleven minutes and clot retraction began within one hour and was complete in five hours.

Complete Blood Count: Hgb. 12.8 gms.: Rbc. 4,150,000: Wbc 13,200: Polys. 13: Seg. 10: Bands. 3: Lymphocytes 70: Monocytes 1: Blasts 1: Atypical lymphocytes 15. Platelet count was 398,400. August 26, a second heterophile agglutination test was positive in dilutions up ot 1:64. By August 29, the glands and spleen had subsided remarkably and the patient felt entirely well. The heterophile agglutination on this day had fallen to 1:32. September 2, complete blood count was as follows: Hgb. 11:30 gms.: Rbc. 3,710,000: Wbc. 6,150: Polys. 28: Segs. 25: Bands. 3: Lymphocytes 60: Monocytes 6: Basophiles 2 and atypical lymphocytes 4. Patient was up and about and was discharged as improved with the diagnosis of infectious mononucleosis. After discharge from the hospital, he was seen again on September 8 and 20. He appeared and felt entirely well and the examination was negative except for a few small glands in the neck and inguinal regions. The spleen could not be felt.

CASE NO. 2

Mrs. M. V., age 39, was first seen on September 5, 1947. She had been well until July when she began to have attacks of headache and vertigo, nausea, vomiting, diarrhea and a slight rise in temperature in the afternoon. She had repeated attacks which required her to stay in bed one or two days. At this time patient was spending her week-ends at a summer cottage on a lake and she was worried about the milk and water supply. September 2 she had an especially severe attack which was associated with aches and pains, extreme weakness and sweating. Her temperature was ranging between 99° and 100°. The examination showed a well developed and fairly well nourished adult female. T. 99⁴, P. 72, blood pressure 120/80. There were small tender glands on both sides of the neck and some in the axillae. The heart and lungs were normal. Abdomen and extremities were negative. A blood smear was examined and this showed many atypical lymphocytes. A tentative diagnosis of infectious mononucleosis was made but on September 9 patient was admitted to the hospital for further study to exclude undulant fever and dysentery. Laboratory work on September 9 showed: Hgb. 11.65 gms.: Rbc. 4,400,000: Wbc. 6,700: Polys. 45: Lymphocytes 42: Monocytes 10: Eosinophiles 2: Basophile 1. Many of the lymphocytes were atypical "mononuclear cells." Tests for typhoid, paratyphoid and undulant fever were all negative and stools were negative for typhoid, other salmonella and dysentery. The heterophile agglutination tests on September 9 and September 12 were considered negative, since agglutination was present in dilution only up to 1:4. On September 12, Hgb. 12.0 gms. Rbc. 4,670,000: Wbc. 6,300: Polys. 42: Lymphocytes 51 per

cent: Monocytes 5: Eosinophiles 2. Many of the lymphocytes were again atypical. Patient was discharged on September 13. At the time of discharge from the hospital, patient felt better. The glands in the neck and axilla were still present. The spleen was not felt. After discharge from the hospital, the patient was seen again on September 19, September 26, and October 3. She had improved but was not able to return to work because of a feeling of lassitude and easy fatiguebility. September 26: Wbc. 6,800: Polys. 43: Segs. 42: Bands. 1: Lymphocytes 38 plus 7 atypical lymphocytes: Monocytes 9: Eosinophiles 2: Basophiles 1: October 3: Wbc. 7,500: Polys. 46: Lymphocytes 39 plus 10 atypical lymphocytes: Monocytes 4: Eosinophile 1: heterophile agglutination test was again negative. In spite of repeated negative heterophile tests, this case was considered to be infectious mononucleosis, because of the clinical picture: the lymphocytosis and the finding of the atypical lymphocytes or "mononuclear cells."

CASE NO. 3

R. B., male, age 22. Admitted to Bridgeport Hospital, September 13, 1947, on the private medical service of Dr. S. R. Smith. The patient gave a history of chills and fever of nine days duration. About 17 days before admission he had complained of low back ache and headache, nausea and flatulence. He had had no sore throat. He had returned from summer camp and had been drinking unpasteurized milk. Otherwise the history was not significant.

Examination on admission showed a well developed, well nourished male. T. 101.4: P. 82: R. 22: blood pressure 122/70: heart and lungs were normal and the abdomen was negative. No glands could be felt and liver and spleen were not palpable. The left eye showed a subconjunctival hemorrhage..

Laboratory examinations: urine negative.

September 13: Hgb. 12.8 gms.: Rbc. 4,800,000: Wbc. 6,250: Polys. 66 per cent: Lymphocytes 31: Monocytes 4: Some of the lymphocytes were atypical.

September 15: Huddleson and Widal were negative.

September 16: Heterophile agglutination test was positive in dilutions up to 1:512.

A diagnosis of infectious mononucleosis was made and the patient was discharged to convalesce at home.

CASE NO. 4

L. R., female, age 13, negro: Admitted to the Bridgeport Hospital, September 26, on the general medical service of Dr. S. R. Smith. Her chief complaint was swelling of the left upper arm of four days duration and vomiting. The arm was painful only on motion. There was no history of trauma or strain. The vomiting had started a few hours after the onset of swelling in the arm. Nausea had persisted and the swelling of the arm had progressed almost down to the elbow. Family history and past history were essentially negative. Examination was as follows: T. 100.5: P. 90: R. 16: blood pressure 124/80. Patient was a well developed, well nourished negro female in no acute distress. The examination was negative except for anterior and posterior cervical adenopathy and swelling and tenderness of the left arm from insertion of the deltoid muscle to the elbow. During her stay in the hospital the patient had vague abdominal complaints and glands developed in the ingu regions.

Laboratory work showed the following: Urine negat

September 26: Hgb. 12.0 gms.: Rbc. 4,230,000: W 6,200: Polys. 43: Lymphocytes 49: Monocytes 6: Eosi philes 2. Sedimentation rate was 6 mm. in one hour. Het phile agglutination test positive in dilutions up to 1:32.

X-ray of the arm was negative for injury or infectio

September 29: Wbc. 9,750: Polys. 57: Lymphs. 32: Mo cytes 7: Eosinophile 1: Atypical lymphocytes 3. Skin was negative for trichiniasis.

October 1: A blood smear showed Polys. 40 per ce Lymphocytes 41 per cent plus 10 per cent: atypical ly phocytes: Monocytes 2 per cent: Eosinophiles 5 per ce Basophiles 2 per cent.

October 2: Wbc. 6,350: Polys. 39: Lymphocytes Monocytes 6: Eosinophiles 3.

Patient was discharged October 2, 1947 with diagn of infectious mononucleosis.

CASE NO. 5

T. K., male, age 17: Admitted to Bridgeport Hospi October 4, 1947, with the chief complaints of sore thro chills, fever, profuse sweating and cough. His illness h started September 27 with a "head cold," aches and pa and sweating. He had been out of school for one week a had been in and out of bed. Four days before admissi patient developed a cough which had persisted. On t morning of admission he developed a slight sore throat a he had a shaking chill followed by profuse perspiration.

Examination on admission to the hospital showed a w developed and well nourished youth of 17 years, acute ill. T. 102: P. 120: R. 24: B.P. 120/74. The skin was war and moist. The nose showed redness and congestion of t mucosa and the throat was moderately inflamed. The ne showed several anterior and posterior glands of vario sizes and there were glands palpable in both axillae a inguinal regions. The heart was normal. The left lu showed many fine moist rales and diminished breath soun and a decrease in resonance over the lower lobe. T abdomen was negative and the spleen was not felt.

Laboratory consultations were as follows: Urine negati on several examinations.

October 4: Hgb. 13.15 gms.: Rbc. 4,500,000: Wbc. 7,05 Polys. 58 per cent: Lymphocytes 20 per cent plus 18 atypic "mononuclear cells": Monocytes 3 per cent: Basophiles per cent.

October 6: Heterophile positive in dilution up to 1:3 Hgb. 12.0 gms.: Rbc. 5,090,000: Wbc. 8,300: Polys. 74 p cent: Segs. 47: Bands. 27: Lymphocytes 20: Monocytes Eosinophiles 2. Icteric Index 7.8 units.

October 6: X-ray of the chest revealed a pneumonia left lower lobe.

October 9: Blood culture negative.

October 10: Hgb. 12 gms.: Rbc. 5,100,000: Wbc. 6,10 Polys. 74: Segs. 59: Bands. 18: Lymphocytes 16: Monocyt 7: Atypical Lymphocytes 3.

October 14: Wbc. 6,100: Polys. 58: Segs. 49: Bands. Monocytes 6: Lymphocytes 35: Eosinophile 1.

Course in hospital: Patient was started on penicillin. The temperature varied from 98° to 103°. On the fifth hospital day, a generalized urticaria due to penicillin developed. Penicillin was discontinued and sulfadiazine was started and on the 7th hospital day the temperature dropped to normal and remained so until discharge. On this same day the spleen was palpable just below the left costal margin and glands could be felt in the neck and axillae and inguinal regions where the glands developed to the size of small almonds. By October 14 the lungs were entirely clear and patient was discharged on October 16. Re-examination on October 21 showed that the patient was well, all glands subsiding and blood taken on this day gave negative heterophile test.

Diagnosis: Infectious mononucleosis and pneumonia, lobar, left lower lobe.

CASE NO. 6

D. M., female, age 3. Admitted to the Bridgeport Hospital on the general pediatric service of Dr. C. C. Taylor on September 28, 1947. The patient was sent in with a diagnosis of acute tonsillitis and nephritis. The history obtained on admission was as follows: The patient had been ill for three days. She had had a "cold," but she became progressively more listless and the mother noticed swelling of the eyelids and that the child was not urinating normally, both as to frequency and amount. The urine appeared concentrated and "smoky." On the day before admission the child became worse and her temperature became high and she was sent to the Hospital for treatment because she was not improving. The past history and family history were negative. The interne who admitted the patient felt that he had not obtained a satisfactory history from the mother.

Examination showed a well developed and well nourished, female child of three years, acutely ill. There was edema of both eyelids to such an extent that the eyes were closed tight. Breathing was rapid and the patient was listless and unresponsive during the examination. The face appeared "puffy" around the eyes and the neck, axillae and inguinal regions showed many glands. The nose was greatly congested and there was a great amount of mucus present. The ear drums were red but not bulging. The pharynx was markedly congested and red and the tonsils were large and acutely inflamed and very angry looking and the crypts contained pus. The heart and lungs were normal. The abdomen was slightly distended. The liver was palpable two fingers below the left costal margin. The temperature was 104° rectal: Pulse 130: Respirations 45. The admitting diagnosis was: Acute tonsillitis—possible infectious mononucleosis: hepatomegaly and splenomegaly.—Rule out leukemia.

Laboratory Examinations: September 30: Urine negative except for a trace of albumin.

October 1-2-4-7: Urine examinations all negative.

September 29: Hgb. 13.15 gms. Rbc. 4,710,000: Wbc. 7,150: Polys. 32: Segs. 21: Bands. 11: Lymphocytes 64; Monocytes 3: Basophile 1:29 of the lymphocytes were atypical.

October 1: Wbc. 12,050: Polys. 25: Lymphocytes 56: Monocytes 4: Eosinophiles 5: plus 10 atypical lymphocytes.

October 2: Hgb. 77.6 per cent: Rbc. 4,140,000: Wbc. 8,600: Polys. 25: Segs. 14: Bands. 11: Lymphocytes 65: Monocytes 4: Eosinophiles 6: 10 of the lymphocytes were atypical.

October 6: Hgb. 10.6 gms.: Rbc. 4,400,000: Wbc. 5,800: Polys. 19: Segs. 15: Bands. 4: Lymphocytes 74: Monocytes 5: Eosinophiles 2: 11 of the lymphocytes were atypical.

October 1: Nose and throat cultures showed Staph. Albus.

October 1: Heterophile positive in dilution up to 1:32.

October 7: Heterophile positive in dilution up to 1:32.

Course in Hospital: Patient was given penicillin 30,000 units q.3.h., nose drops of ephedrine and penicillin and aspirin and clysis. Later because of the severe infection of the throat, sulfadiazine was given for three days. The temperature ranged from 98° to 104° rectal and dropped to normal on the fourth day. On October 6 the edema of the face and eyes was gone. On October 7 the throat appeared normal. All glands were subsiding, the liver and spleen had diminished in size and they could not be palpated. The patient was discharged on October 7, with a diagnosis of infectious mononucleosis.

The accompanying table is a summary of laboratory findings, symptoms and signs of all cases.

DISCUSSION

It is evident from the preceding table that in several cases only one white count and smear was done and no test was done for heterophile agglutinins. This is especially true of cases which were seen at home. On these patients the diagnosis was based on the history and physical examination and the examination of one or more blood smears. In some cases it was not possible to obtain a follow-up blood count or blood for the Paul-Bunnell test. We feel that the blood smears were so typical of infectious mononucleosis that there was no doubt in our minds about the diagnosis. The smears all showed an increase in lymphocytes and many atypical lymphocytes or "mononuclear cells." In view of the number of cases seen in a relatively short period of time and by comparison of the blood smears of those which had complete counts and heterophile tests with those which had incomplete tests, since the blood pictures were similar, we felt justified in adding these cases to our series.

There were twenty other cases seen which we felt were infectious mononucleosis on the basis of physical findings but they have not been added to this series because no blood count or heterophile test was done and the only laboratory test was the examination of one blood smear.

The Paul-Bunnell test is an excellent aid and no doubt the last word in confirming the diagnosis, especially in sporadic cases or in cases in which a

CASE NO.	PATIENT	AGE	DATE	HGB. GRAMS	R.B.C. MILLIONS	W.B.C. THOUSANDS	POLYS.	TOTAL LYMPHS. NORMAL	TOTAL LYMPHS. ATYPICAL	MONO.	BASO.	EOS.	BLASTS	PAUL BUNNELL	SYMPTOMS AND SIGNS
1	G.S. ♂	11	8/23	11.3	4.6	14.1	16	66					14		Fever, cough, many glands, spl
			8/24											Pos.	
			8/26	12.8	4.1	13.2	13	70	15	1	1			Pos.	
			9/2	11.3	3.7	6.1	28	60	4	6	2				
2	M.V. ♀	39	9/9	11.6	4.4	6.7	45	32	10	10	1	2		Neg.	Fever, sweats, glands, lassitude, he
			9/12	12.0	4.6	6.3	42	36	15	5		2		Neg.	ache, nausea, diarrhea
			9/26			6.8	43	38	7	9	1	2			
			10/3			7.5	46	39	10	4		1		Neg.	
3	R.B. ♂	22	9/13	12.8	4.8	6.2	66	31		4					Chills, fever, weakness
			9/16											Pos.	
4	L.R. ♀	13	9/26	12.0	4.2	6.2	43	49		6			2		Fever, vomiting, many glands
			9/29			9.7	57	32	3	7		1		Pos.	
			10/1				40	41	10	2	2	5			
			10/2			6.3	39	52		6		3			
5	T.K. ♀	17	10/4	13.1	4.5	7.0	58	20	18	3	1				Fever, sore throat, many glands,
			10/6	12.0	5.0	8.3	74	20		4		2		Pos.	spleen, left pneumonia
			10/10	12.0	5.1	6.1	74	16	3	7					
			10/14			6.1	58	35		6		1		Pos.	
			10/21											Neg.	
6	D.M. ♀	3	9/29	13.1	4.7	11.1	32	35	29	3			1		Fever, sore throat, glands, palpat
			10/1			12.0	25	56	10	4		5		Pos.	liver and spleen, edema of face
			10/2	11.6	4.1	8.6	25	55	10	4		6			
			10/6	10.6	4.4	5.8	19	63	11	5		2			
			10/7											Pos.	
7	A.C. ♂	37	9/9	15.2	5.4	7.4	60		38	2					Chills, fever, sweats, weakness, he
			9/20				51	30	15	3		1		Neg.	ache, loose stools
			9/30			7.0	44	43	5			8			
8	A.M. ♂	15	9/27	13.1	4.7	11.8	66	14	15	4		1			Sore throat, fever, many glands
			10/1											Neg.	"Scarlet Fever rash," cough
			10/4			7.8	39	31	19	7	2	2			
			10/25			7.2	74	9	14			3		Neg.	
9	E.H. ♂	28	9/27	13.5	5.2	8.7	51	20	14	10	1	4			Weakness, sweats, glands
			9/30											Pos.	
10	N.C. ♂	42	10/1				61	20	15			4			Fever, sweats, weakness, diarrhea,
			10/2	14.3	4.8	9.4	43	33	14	7	2	1		Neg.	adbominal pain
			10/8											Neg.	
			10/9			10.0	57	32	4	6		1			
			10/22											Neg.	
11	E.C. ♀	38	9/28				51	28	12	7		2			Fever, sore throat, sweats, weaknes
			10/2			8.2	53	21	23	1		2		Neg.	diarrhea, abdominal pain
12	D.C. ♀	11	9/28			9.8	58	13	19	8		1			Sore throat, fever, glands
13	D.C. ♀	6	9/29			11.6	59	22	18	1					Sore throat, fever, many glands
14	D.K. ♀	14	10/4	12.8	5.4	5.0	45	45	5	4		1		Pos.	Fever, sore throat, cough, glands
			10/9			6.2	44	36	8	10	1	1		Neg.	sweats
15	G.C. ♂	50	10/4	15.2	4.9	9.0	53	35	4	6		2			Ambulatory-cough, weakness, sweats for three weeks

PATIENT	AGE	DATE	HGB. GRAMS	R.B.C. MILLIONS	W.B.C. THOUSANDS	POLYS.	TOTAL LYMPHS. NORMAL	TOTAL LYMPHS. ATYPICAL	MONO.	BASO.	EOS.	BLASTS	PAUL BUNNELL	SYMPTOMS AND SIGNS
B.H. ♂	6	10/6	10.9	4.2	11.3	48	27	15	5		5			Fever, cough, sore throat,
		10/14			8.7	29	40	23	3	1	4		Neg.	many glands
R.D. ♀	24	10/6	13.5	4.6	17.5	64	27	3	1	1	4			Weakness, sweats, abdominal pain,
		10/8			9.1	51	35	8	4	1	1		Pos.	nausea
		10/22	12.8	4.8	13.5	69	19	3	4	1	4		Neg.	
W.L. ♂	7	9/15	11.6	3.7	13.1	87	6		7					Fever, sore throat, abdominal pain
		9/17			7.7	75	12	2	7	4				Glands, Furuncles treated with
		9/21			7.5	43	41	4	5	4	3		Pos.	Penicillin
M.S. ♀	14	10/2				53	43		3			1		Fever, sore throat, cough, glands
		10/11			6.8	58	27	4	5		6		Neg.	
M.D. ♀	22	10/6			6.5	68	14	10	4		4			Fever, sore throat, cough, glands,
		10/11			6.2	40	44	8	6		2		Neg.	weakness
E.S. ♂	3	10/21	11.3	4.4	17.6	17	63	17	1		1	1		Fever, cough, tonsillitis, many glands, spleen
B.H. ♀	7	10/24	11.6	4.4	25.7	20	14	61	3		2		Pos.	Fever, rash, sore throat, many glands,
		10/29			8.7	15	24	58	2		1			spleen
V.V. ♂	16	9/12	16.6	5.5	10.0	35	8	50	7					Headache, general malaise, nausea,
		9/16			7.8	53	15	27	5					fever, sweating, general lymphadeno-
														pathy
F.S. ♀	27	10/27			6.0	64	13	20	3				Neg.	Mother of E.S. (Case No. 21) Headache, fever, pain behind left eye, sweats, cervical adenitis

fficult differential diagnosis is involved. But, if the sease is suspected especially during epidemics and pical differential blood count is found with an crease in lymphocytes and atypical lymphocytes, ere should not be any serious doubt about the agnosis.

Krache,[4] in his book on hematology, says that the typical lymphocyte is specific for infectious ononucleosis and should act as a definite diagnostic iterion for the disease."

We were disappointed in the number of negative eterophile agglutination tests reported, but unless equently repeated tests are done, the blood may e obtained at times when the titer is low, and me patients may never develop titers sufficiently gh to give a diagnostic test.

NCLUSIONS

A number of cases of infectious mononucleosis hich were seen within a short time are reported. his would tend to indicate the presence of an pidemic at the time. Because of the number of cases en and because in some families more than one member was ill, we feel that infectious mononucleosis is more highly contagious than is usually believed. One of the authors and his entire family of four were victims of the disease. Most of the symptoms were of an upper respiratory, glandular and gastro-intestinal nature. The majority of the patients recovered promptly, the children usually in a week or two and the adults in two or three weeks, with the exception of two adults who were still complaining of lassitude and weakness and excessive perspiration three months after the onset of illness. None of the cases in the present series were of a serious nature. The reports which have appeared in the literature since World War II,[5,6] should make it evident that infectious mononucleosis is more common and widespread than was previously believed.

Recent reports in *Blood—The Journal of Hematology*[7,8,9] show that the disease may have serious complications. Rupture of the spleen[7,8] and purpura[9] have been reported. Because of the protean manifestations and possible complications the disease should be kept in mind and attempt should be made

to establish the diagnosis on all cases, for the benefit of the patient—so that complications may be anticipated and possibly forestalled.

BIBLIOGRAPHY

1. Editorial: J.A.M.A. Vol. 134-18: pp. 1548-49. August 30, 1947.

2. Downey, H. and McKinley, C. A.: Acute Lymphadenosis compared with Acute Lymphatic Leukemia: Arch. Int. Med. 32:82. 1923.

3. Wintrobe, M. M.: Clinical Hematology, Philadelphia, Lea and Fehiger, 1946.

4. Kracke, R. R.: Diseases of the Blood and Atlas of Hematology. Philadelphia, J. B. Lippinicott, 1941.

5. Walker, William H.: Infectious Mononucleosis. B letin, U. S. Army Medical Department. December, 1944.

6. Gardner, Horace T. and Paul, John R.: Infectious M onucleosis at New Haven Hospital. 1921-1946. Yale J. B and Med. 19-839. May, 1947.

7. Smith, E. B. (Major) and Custer, R. P. (Lt. Col): R ture of Spleen in Infectious Mononucleosis: Blood Vol. 1 pp. 317-33, July, 1946.

8. Vaughn, Stuart L., Regan, J. and Terplan K.: Infecti Mononucleosis complicated by Spontaneous Rupture of Spleen and Central Nervous System Involvement. Blo Vol. 1-4: pp. 334-338, July, 1946.

9. Dameshek, William and Grossi, Michael A: Infecti Lymphadenosis and Thrombocytopenic Purpura: Recov after Splenectomy. Blood, Vol. 1-4, pp. 339-342, July, 19

THE UTILIZATION OF A UNIVERSITY CANCER CLINIC FOR TEACHING PURPOSES

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TEACHING facilities in a University Clinic are provided in general for three categories of students: (a) medical students, (b) graduates, which include special fellows in addition to the members of the house staff, and (c) interested physicians in the state. At Yale, the cancer clinic, in the ordinary connotation of the term, is not an autonomous unit but is one of the articulating facets of a broad organization dedicated to the study of neoplastic disease. A discussion, therefore, of the utilization of the cancer clinic for teaching purposes cannot, if it is to be complete, confine itself to this one facet but must touch upon the whole organization. The most expedient way to do this is to outline first the general structure of the tumor service at the Yale University School of Medicine and then to indicate how each category of students participates in it.

In recent years an attempt has been made to coordinate the study of neoplastic disease and to develop a unified program which would provide for a close integration of all the divisions in the School that are concerned with this subject. The broad pla which was projected and which is now functionin at many points is represented in Fig. 1. It will be see that the hub of the scheme is the Detection an Tumor Clinic. The Tumor Clinic was organized i 1929. It meets three mornings a week and admi ambulatory patients of all economic levels who hav neoplastic disease or who are suspected of havin

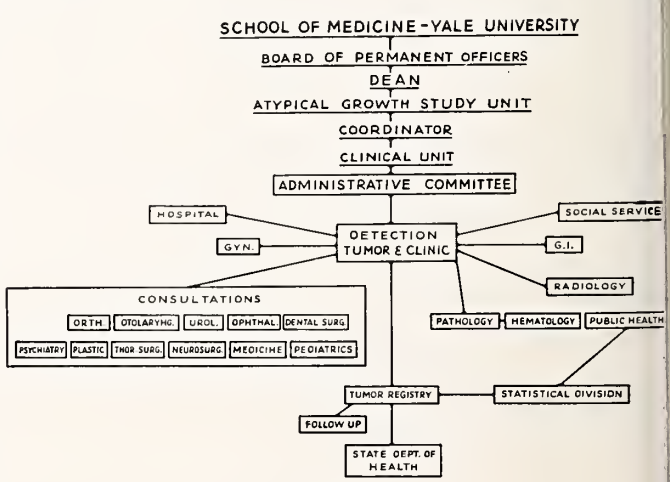


FIGURE 1

Organization of unit for coordinated study of neoplastic disease, Yale University School of Medicine

Presented at the Meeting of the Clinical Congress of the American College of Surgeons, September 9, 1947, New York, N.Y. From the Atypical Growth Clinical Unit, School of Medicine, Yale University. Aided by grants from The Jane Coffin Childs Memorial Fund for Medical Research, The Connecticut Division of the American Cancer Society and the National Cancer Institute of the National Institute of Health, U. S. Public Health Service

oplastic disease. Patients are referred to the Clinic the various divisions of the New Haven Hospital, other tumor clinics in the state, by practising ysicians, by social agencies and by former tients. The Clinic is concerned with the functions diagnosis, therapy and follow-up. All new tients are examined by the conventional clinical ethods, which include routine and special laborary procedures, roentgen studies and biopsies. herapy, radiation as well as surgical, is carried out hen it is feasible to do so on an ambulatory basis. tients who require hospitalization for definitive eatment are admitted to the New Haven Hospital d are then referred back to the Clinic for further re and for follow-up until termination of the se. Because of the direction of flow of the case aterial, the Clinic is under the aegis of the Departent of Surgery, but it has always functioned in the osest cooperation with the Surgical Pathology and e Roentgenology divisions. Patients who require e services of other specialists for diagnostic and erapeutic measures are referred to the appropriate partments, either as inpatients or outpatients cording to the demands of the particular case. nce the clinic is the funnel through which patients ith all types of cancer pass, it is a logical place om which to project clinical studies on special hases of neoplastic disease. Plans are under way for coordinated study of cancer of the breast and it is nticipated that a similar project in reference to astro-intestinal malignancy will be developed in e future.

The Detection Clinic was organized in February 947. As the name implies, its function is to screen resumably healthy people in an effort to uncover he presence of neoplastic disease at the earliest posible stage, when it has not yet revealed itself in he form of symptoms and when, theoretically at east, the outlook is most hopeful for complete radication of the disease. A complete history is aken and a thorough physical examination is performed in every case. In adult females, a pelvic xamination is made by a senior member of the ynecology department, and cervical smears are prepared for study according to the Papanicolaou echnique. The laboratory investigation includes lood serology, a complete blood count, urine nalysis and stool for blood. A photoroentgenogram s taken of the chest. If, as a result of these studies, a uspicion of the presence of cancer is aroused, furher specialized diagnostic procedures are recommended. These are carried out either by the clinic or by the local physician, according to the desire of the patient. At first, only patients without known neoplastic disease were subjected to this screening process. In view, however, of the not infrequent occurrence of multiple primary cancers, it did not seem appropriate to deny patients with established neoplastic disease the advantages of the screening examination. Accordingly, every new patient in the Tumor and Detection Clinic, regardless of his history and presenting symptoms, is completely processed.

The Tumor Registry is the repository of the pertinent records of all patients with malignant neoplastic disease that are admitted to any division of the New Haven Hospital. The existence of malignant disease must in each instance be proved by a positive histological examination of tissue obtained either in vivo or at autopsy. Besides providing a mechanism for the continuing follow-up of all patients with cancer, the registry has accumulated a vast storehouse of clinical material which is available for study and analysis. The affiliation of the statistical division of the University Department of Public Health with the Registry makes it possible to catalogue all data in such a manner that significant statistical surveys can be readily and accurately accomplished.

The Social Service unit forms an important cog in the organization. In addition to eliciting information that reveals the patient to us as a human being and as a member of a complex society rather than as another "case" of cancer of the breast, or stomach, or lip, it is accumulating essential social and economic data which can be analyzed to determine whether these factors play an important causative or aggravating role in malignant disease.

Problems in diagnosis or treatment as well as interesting examples of neoplasia are presented at the Tumor Conference, which meets once every week throughout the school year. An analysis of each case is made by a member of the Departments of Surgery, Radiology and Surgical Pathology respectively, and the subject is then opened for general discussion from the floor.

The clinical program in oncology described above is directed by the Clinical Unit Administrative Committee composed of representatives from all the major divisions articulating with the Detection and Tumor Clinic.

The Atypical Growth Study Unit "brings together from various departments of the School and

University investigators who are working on problems of growth with special reference to neoplasms. Its membership includes representatives of anatomy, biology, botany, genetics, organic and physiological chemistry, pathology and surgery. Meetings are held twice a month from October to June. The seminars, reports, and lectures by invited speakers present coordinated accounts of researches in special phases of the general problems of atypical growth."

The link between the Clinical Unit and the Atypical Growth Study Unit is provided by the Coordinator, a senior member of the surgical service who has a broad experience in the entire clinical field of cancer, who has an intimate familiarity with research in cancer, and who therefore occupies the strategic position where on the one hand he can apply in the Clinical Unit the knowledge that is uncovered by research, and on the other hand can suggest for investigation in the laboratory the problems that arise in the Clinic.

OPPORTUNITIES AVAILABLE TO MEDICAL STUDENTS TO LEARN ABOUT CANCER

During their third and fourth years of residence at the School the students serve as clinical clerks in all the clinical divisions. Patients with neoplastic disease are at hand for study in each of these divisions but the students receive the bulk of their exposure to problems in clinical cancer during their clerkships in general surgery, in the various surgical specialties and in gynecology. The relatively large number of patients with cancer that are admitted to the general surgical service has made it feasible to concentrate them all in a separate tumor subdivision, which is under the immediate supervision of the coordinator. For one of the twelve weeks of his clerkship in general surgery the student is assigned to the clinic where he sees a concentration of ambulatory patients in all stages of malignant disease. The teaching is not in the form of didactic lectures and demonstrations but is based rather upon clinical case material which serves as a text for informal discussions. All the students in the school are invited to attend the Tumor Conference. Opportunities for more intensive study in both the clinical and preclinical phases of the subject are provided by elective courses where the students are required to survey the recent advances in the field as revealed in the current literature and to present a critical report in small group seminars. Finally those students who have demonstrated special interest and ability are encouraged to participate in original investigative work that is being carried on in the various dep ments of the School.

OPPORTUNITIES AVAILABLE TO HOUSE OFFICERS AND FELLOWS TO LEARN ABOUT CANCER

During his internship the surgical house offi is rotated through the following surgical disciplir general surgery, neurological surgery, thoracic s gery, urology, orthopedics and gynecology. H thus brought into intimate contact with almost entire gamut of neoplastic disorders. After spend a year in the laboratory, he progresses to a two y assistant residency in which except for gynecolo he covers the same ground but on a higher le From there he proceeds to a one year appointm as chief resident in one of these branches. Th interns who are particularly interested in neopla may elect to spend a year in the Detection a Tumor Clinic in lieu of their "laboratory year." the clinic they are the ones who make the fi contact with the patients and, under the supervisi of the director, have the full responsibility f diagnosis, treatment and disposition of the cas Under the guidance of the senior surgical patho gist, they are responsible also for examinatic description and diagnosis of the surgical specime that are sent down from the operating rooms of t hospital. At present three fulltime assistant reside are assigned to the clinic. In addition there has be since the termination of the war at least one po graduate student, a "G.I. Fellow," in attendance.

For the past five years funds have been availab for the appointment of special fellows in canc study. Each fellowship is for a two year period a includes eight months in the clinic, eight months radiotherapy and eight months in surgical patho ogy. It is expected that the fellows will in additi find time to engage in cancer research. This ye it has been possible also to appoint a senior fello in cancer study whose duties will be divided b tween the clinic and investigative work. All t assistant residents and the fellows associated wi the clinic attend the Tumor Conference regularl All are invited to the lectures sponsored by t Atypical Growth Study Unit.

OPPORTUNITIES AVAILABLE TO PRACTISING PHYSICIANS TO LEARN ABOUT CANCER

The clinic and the Tumor Conference are ope to all physicians without charge. The time and pla of these functions are published in the official Sta Medical Journal. An indirect but not inconsiderab

tching channel is provided by the letters that are sit by the director of the clinic to the "referring physician." These letters contain a brief but complete summary of the essential physical findings, the boratory analyses, the suspected diagnosis and the commendations for further investigation and eatment. In the course of time many physicians all er the state are reached in this manner and a great al of cancer education is widely and subtly disminated.

These, then, in brief are the facilities available for rning about cancer in one University Clinic. mphasis is deliberately placed upon the word "learning" rather than "teaching." Stimulus, guidance, a wealth of case material, an unsurpassed library, and ample laboratories are provided by the faculty and by the administration. It is the student's own responsibility to dig in and to avail himself of these facilities. An effort is being made at Yale to join in a closed circuit all the forces that are engaged in the study of neoplasia so that a student who makes contact at any point in the structure cannot fail to be stimulated by currents that flow from many generators and that serve to activate and to vitalize the whole.

GOVERNMENT AND MEDICINE

James Raglan Miller, m.d., *Hartford*

t has been a great privilege to serve you as president during the past year. I have felt the honor the position and am deeply grateful for your nfidence.

It is part of the obligation of this office that I ink upon those things which are the concern of e profession in our State and if possible distill some oughts for your benefit on this occasion.

The basic tenet of our representative democracy that government rests on the consent of those overned. This is true also for our medical democy. More and more in the world today we are ced with two views of the function of govern-ent.

One of these views extolls the efficiency of the entralized state and submerges the individual to e authority of an all powerful central government. he other is that the individual himself is of upreme consequence and that the state is his servant. While there have been many evidences of pressure oward centralization of power in Washington, I an assure you from personal observation that there s no movement within organized medicine toward dictatorship in Chicago.

Most physicians are strongly opposed in principle o centralization of power but some, for reasons which have peculiar attraction to them, are led to advocate social changes which cannot operate without the exercise of strong federal authority.

Against this background of conflicting ideologies advocates and opponents of certain well known legislative projects take positions for or against with a fervor which is almost religious. It is not in the spirit of contention that I address you today but rather in that of thoughtful consideration.

We observe all shades of opinion between these two extremes. Bernard Baruch has pointedly said that the picture is not all black or all white but gray. Former President Calvin Coolidge was accustomed to emphasize individual initiative and often decried the tendency of individuals and groups, communities and states, to run to Washington at the slightest provocation to investigate and solve problems which were properly of local concern. There are, however, some health services which can be operated only by government either alone or with the cooperation of private enterprise.

The problem stated in simple terms is this: we wish to obtain for everyone the maximum benefits which can be derived by pooling our efforts and resources, without at the same time losing individual freedom of choice and freedom of action. What is

The President's address given at the 156th Annual Meeting of the Connecticut State Medical Society, Fairfield, April 9, 1948

the proper relationship of government and medicine? Are we in Connecticut making progress, and if progress is being made, is it fast enough? Can we hope to continue successfully using these same methods? I can tell you at the start that I believe we are on the right track and that we have been making substantial progress, and furthermore that there is no health crisis in Connecticut which calls for a revolutionary change in our methods.

During the depression of the 1930's we observed the lengths to which people are willing to go when their economic security is threatened. Under the stress of hunger, cold and want, freedom itself is apt to be bartered for a mess of pottage. During that period we learned how difficult it is to furnish the necessities of life including medical care to those who are unable to provide for themselves.

Our experience with the Volstead Act showed that laws which are passed even with the best of intentions to accomplish a socially desirable end cannot become effective unless they harmonize comfortably with the social habits and with the conscience of our people. Such social legislation often works out differently than is anticipated. If laws and regulations are not supported by overwhelmingly favorable sentiment, they will become ineffective even with the exercises of tremendous police power. The bootleg trade of the Volstead days and the black markets of the war testified to the difficulties confronting any law which deviates from sound economics and runs counter to the habits of the people and to the immutable laws of human behavior. Failure often occurred because no account was taken of the emotional reactions of people subjected to regulations which are inevitable in the administration of such laws.

During the war the nation knew it was in a struggle for existence. We were in fear of extinction, or at least of subjugation to a foreign power. This led us to accept regimentation and sacrifice for the common good to an extent that is intolerable in a democracy in times of peace.

When there is infection in the human body the white blood cells are greatly increased in number. Not only is the total count increased but there is an increase in those particular cells which fight infection. For reasons which do not concern us, this change in the relative number of polymorphonuclear leukocytes is called a "shift to the left." Physicians have learned that it is natural to have a high white blood count and a high differential count in the presence of fever. We recognize i as one of the natural defensive mechanisms of body just as we expect to have fever in the prese of infection. When, however, the episode of dis is over, we expect that the blood count as wel the temperature will return to normal, and if find the "shift to the left" continuing and a p sistence of an abnormally high count, we are clined to think that the body is afflicted w leukemia, and the outlook for the patient's fut is not good. So also when emergency powers nec sary for government in times of stress are carr over unduly into normal times, we may indeed concerned over the health of the body politic. W therefore approve the discontinuance of the Em gency Maternal and Infant Care program for me bers of the armed services. We recognize the cla of veterans on the government for medical care f service connected disabilities, but disapprove t extension of these benefits to dependents of vetera and to veterans for non service connected disab ities unless bona fide need can be shown.

In the gray area referred to by Mr. Baruch b tween the two views of public and private effort wish to explore the proper place for government health programs. This is one of the foremost co cerns both of government and of medicine. Ma answers are advanced. Some sort of an answer w be arrived at. It is demanded by both major politic parties. I cannot hope to give you a perfect answ but at least I shall try.

In general we recognize both preventive a curative medicine, but all of us know how difficu it is to draw a sharp line between the two. If o is to draw such a line, and I think that it is usef to try, it becomes evident that the position of th line will be different in war than in peace, and isolated communities it will be different from th position which it holds in urban and well develope areas. The line would be modified also according t the economic status of the area. Certainly the lin would be modified by discoveries of methods whic lend themselves to mass application and we mu recognize that the difference between the two wi vary according to the social maturity of a give community and also to the adaptability and wisdo of government. I use the term social maturity in i broadest sense including economic maturity. Ther is no universally applicable formula dividing pre ventive from curative medicine.

If then there are no hard and fast rules, it is sti

possible to enunciate certain broad principles which define the areas in which government and private agencies respectively should function.

1. Government should do those things which it can do well and which individuals and private enterprise do not do well.

2. Government should assist private citizens to the extent to which they are unable to provide for themselves and should withdraw support as soon as possible.

3. The direction of effort should be toward developing local and individual resources and to diminish the need for prolonged support by public funds. This is a point of view which is natural for physicians and it is unnatural for the bureaucrat. The physician aims to make it unnecessary for the patient to remain under treatment for a given disease any longer than is necessary. It is his conscious effort to reduce the patient's dependency upon him for services in disease though he remains a health counselor and guide. The bureaucrat on the other hand views with alarm the fulfillment of his function to the point where it is no longer necessary for him to operate.

What then are the health services which government does best? There is no dispute concerning the propriety of health departments acting to collect vital statistics and to study records of marriages, births and deaths. Sanitation and environment and communicable disease control are necessary public functions. All these operate well only when they are financed by tax funds and backed by the police power of the state. In recent years health departments have extended their fields of operations to include health education, public health nursing, and maternal and child health services. These too have been generally accepted as proper fields for public health activity. There is a difference, however, between these and the first services mentioned, for in the newer services cooperation of individual physicians must be obtained and cooperation of the organized profession in an advisory and even in an executive capacity is highly desirable.

There is much to be said for the employment of full time health officers, not only in our cities but in small towns grouped into health districts. In spite of the fact that this development is recognized throughout the country, and has the approval of both our State Society and the American Medical Association, some of our individualistic physicians do not yet see the advantages of this program and consequently the district health program will be slow in unfolding. Some physicians look on these public health extensions not as services that can help them provide for their patients, but as ever expanding public enterprises which tend to grow greater and greater and in the end to replace the family physician. The confidence of the practitioner of medicine must be gained by showing him benefits and allaying his fears. Even though it is a slow growth and our health commissioner and others may be impatient with the progress, I maintain that it would be folly to impose the program from above down. It is a wise provision of our Health District Law that it provides for the establishment of health districts at the request of the local communities and furthermore requires joint financial participation by the local community and state.

We are witnessing a tremendous outpouring of federal tax funds in the support of medical education and research. In both of these fields it is proper for the government to make a substantial contribution, particularly in those areas where individual effort is unsuccessful, and where funds are needed most but are not forthcoming. The amounts of money are great and we should realize the wisdom required to see that these programs of aid stick closely to their purposes and do not become vehicles for political manipulation. So far as I have observed there is every disposition at the present time to keep this area clean and productive, but politics has a way of following appropriations.

In the area of curative medicine most physicians believe that governmental agencies have less right to be proud of their accomplishments. The great service of the medical departments of the armed forces during the last war is a monument to the accomplishment of reserve officers who made that record possible. Certainly in those medical services which call for personal relationship between physician and patient, it is the course of wisdom to develop the ordinary patient-physician relationship that the citizen is accustomed to under normal conditions. Where adequate provisions for medical care are not available, they should be furnished as far as possible through private practitioners who are suitably recompensed.

In certain instances some of the well proven services are properly given free to all at the physician's request. We have, for example, accepted the use of state laboratories for the diagnosis of syphilis, tuberculosis, or tissue diagnosis and various other labora-

tory procedures.

All of the items I have mentioned are aids to medical diagnosis which lend themselves to mass application. They can be done with economy and without loss of quality. The field for such development is great and is an entirely proper function of government. No greater advance can be made in our system of medical care than to make available to the general practitioner reliable laboratory, x-ray and consulting services at prices which the patients can afford to pay. Again if patients are unable to meet the expense, assistance should be arranged through the patient's physician who knows the needs. The graduate coming out of our medical school today is a very capable fellow. He is accustomed to use the tools of modern diagnosis and if they are readily accessible, there will be less difficulty in persuading him to settle in rural areas.

Society's interest in protecting itself against tuberculosis as a contagious disease and also as a costly tax problem has led to extensive programs of chest x-ray diagnosis. This service is now available to physicians for the asking. It is wasteful and disturbing to sound medical care for patients to walk in off the street and demand such services directly. We have learned that the chest films are subject to considerable error and are not the exact diagnostic method which the public assumes. The results of this x-ray and other laboratory studies must be interpreted to the patient and made use of in the correction of his defects and the establishment of sound habits of living.

It would seem to me more productive to keep keen the diagnostic ability of two thousand or more practicing physicians in Connecticut than to provide elaborately equipped diagnostic clinics in a few scattered localities. Formally organized clinics should be reserved for problem cases; they should be developed in and about our hospitals with state aid perhaps but not with state operation.

The public health nurse is generally accepted by the profession as a necessary and desirable part of our health system. Time was when she was looked at obliquely by physicians as a possible competitor. That time has passed and she is now the physician's right hand.

Health education and physical education are the proper functions of government. They are the combined responsibility of departments of health and education. In this program the individual physician too has a part to play, even though he may not participate in any of the school physician activit or take part himself in a well baby or crippled ch clinic. Every physician owes it to his patient instruct him in habits of good personal hygie how to take care of himself, and how to establi habits that will lead to positive health. It is his du to instruct his patient to recognize disease and in doing to maintain a sound mental attitude towa disease and toward his own future.

The ability to care intelligently for oneself is the utmost importance in the early diagnosis cancer and of many other degenerative diseases. N state program for the care of chronic illness ca make headway if it does not teach the basic facts health and disease which all should know and th instruction should come as early as possible.

There is now before Congress legislation (S1290 which illustrates the emotional appeal of sickne among children. Men of good will have been led t seize upon the fact that school children from 5 t 17 years are under well nigh complete control the school authorities. The opportunity afforde seems too good to be missed and the Children Bureau needed little urging to step into the pic ture. This bill proposes not only to prevent an diagnose but also to treat and cure both physica and mental defects of all school children. Th pattern and implication are almost Russian.

It is contrary to all sound principles to divid medical responsibility between school physician and family physician in such a manner as to displac the latter. It is better to teach parental responsibility for the medical care of the child, to furnish follow-up system to see that those responsibilitie are met and to arrange assistance where that i needed. In Hartford we do not even vaccinat children in the schools. The child's physician doe that. More and more we are providing examinatio forms so that he may conduct the health examina- tion himself. This pattern, not the one developed i S1290, will appeal to most physicians. The ability to care for oneself intelligently cannot be developed in people who from childhood are relieved by the state of the incentive to provide for their own security. In New England we are certain of that.

Every physician in Connecticut can take pride in the part that our Society has taken in the founda- tion of the Yale Medical School, in the foundation of the Hartford Retreat, now the Institute of Living, in the establishment of our hospitals for medical defectives and for the insane, in the establishment

the State Department of Health itself, and now in the development of a postgraduate program in cooperation with the Yale School of Medicine.

All down the years our physicians have cooperated with the state and local agencies in developing health program, in serving on advisory committees, in war and in peace, and do not forget the most important function of all, the examining board for the licensure of medical practitioners. At the present time there is scarcely a state commission which has important interests bordering on health which does not number among its ablest members physicians who have been persuaded to accept this public duty by our Society. This relationship works with ways for sound cooperation and obviates painful and vexatious debate. The State Department of Health seldom takes a step in the area of health services without the advice and cooperation of our Society. This is a happy relationship and one which hope will continue. It is idle to say that our points of view do not differ at times, but they are adjusted in mutual respect and I am sure to the benefit of the people.

Our Society has maintained intimate and pleasant contact with the programs conducted by the Commissioner of Public Welfare, Commissioner of Education, the Veteran's Administration and with the development of the program for chronic illness and for alcoholics, and in the study and the development of the program under the hospital construction act. Our relationships with government are many and they are intricate. They have to do not only with local and state matters, but with programs which come from the federal government in which there is a distribution of federal funds through our state authorities as agents. I have on many occasions called attention to this increasing scope of activities on the part of our Society because Dr. Barker and the administration of his office, in order to be effective for the physicians of the state, must have the understanding and the backing of all our members. You have given that support in the past and with all the urgency at my command I ask you to continue.

We look across the water to our friends in Great Britain and study carefully the succession of events. We note that the pattern of the British Health Insurance Act was conditioned largely by the previous experiences with the so-called Friendly Societies. It was easier to take over and build on a system already developed than to establish a new one. In a similar manner it has been suggested that the future pattern of state medicine in this country, if and when it develops, would be greatly influenced by the experience which is now being gained with our voluntary plans. Those who look with concern at the future of our profession might well ponder on this line of reasoning.

I am not one of those who feel that the voluntary systems inevitably lead to compulsory medicine just because this has been the pattern abroad. If through war or adversity our society is reduced to experience the economic scarcities obtaining in other countries, we may, of course, follow their pattern. The United States, however, has developed a habit of accomplishing the seemingly impossible. Nowhere in the world has voluntary effort been mobilized so successfully and on such tremendous scale as in this country, and there are many who believe that the spirit of freedom embodied in this voluntary effort is one of the reasons for our greatness.

One gains the impression from casual observation in the headlines of the daily press that the American Medical Association and the government are at odds. It is true that certain differences of opinion exist between us and the present administration and that some of the differences are fundamental in character and in areas which attract attention and lend themselves to dramatic exploitation in the press. Attention is apt to be distracted away from the many evidences of cooperation which organized medicine has developed with our national government. This evidence is extensive and convincing. It is proof of the willingness and desire of physicians to play a constructive part in the national economy. During the war the American Medical Association's biographical file of all physicians in the United States was put at the disposal of the government and served as the basis of all personnel work in the medical departments of the armed forces. The cooperation of our profession with government in developing the draft machinery is common knowledge. The part that the American Medical Association played in the development of pure food and drug standards, and in opposition to unscrupulous and misleading advertising, is a truly great service to the people and in the field of medical education the service of organized medicine to the public is supreme.

Some of these and other functions cannot be done by government alone. Most of them are in Mr. Baruch's gray area, and I am glad to say that in

developing these cooperative efforts with government the profession is better organized than ever before for public service.

In a study entitled "Medical Care for the Individual" made by the Brookings Institution at the request of Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, I find the following conclusion:

"For the time being the National Government and many of the State governments may well devote their resources and energies to:

(a) Research and developments in the fields of public health;

(b) Health education at the school level;

(c) Teaching of preventive medicine;

(d) Assisting in the acquisition of physical facilities and training of personnel;

(e) Providing systematic care for the indigent and the medically indigent. In some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and coordinated program."

". . . governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, state, and local voluntary organizations which have been al to enlist the active cooperation of leading laym in most sections of the country. It must be reme bered that good health is not exclusively a mat of medical care; it also impinges upon causati factors that are non medical, such as food, shelt vice and crime, transportation and industry." T I believe is sound advice.

More than two years ago Senator Robert T made the following statement: "Our policy is maintain a minimum standard floor under subsi ence, education, medical care, and housing. I belie that our people have decided that our producti ability is so great that we will undertake to put floor under the essential things to give to all minimum standard of decent living and to all ch dren a fair opportunity to get a start in life." W can all subscribe to this statement and I know th every member of this Society will wish us to for ahead in our customary place of leadership yoking state and private effort to pull for the publ good. A successful marriage assumes without co tentious dispute the rights, privileges and prop sphere of activity of each partner and devotes i thought and energy to promote its common pu pose. So with medicine and government in Co necticut.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Reflection

Those who attended the meeting of the House of elegates, held in Bridgeport on April 17, came vay with an increased awareness that the business f the Society has grown to large proportions. That is being handled wisely and expediously is assured, or experts tell us that the Society stands on a sound nancial structure and that our affairs are in good rder. The meeting was also impressive from the cts of its prompt and full attendance and the rderly deliberation and dispatch with which the genda was carried forward. The important decision y the House to proceed to develop a prepayment edical care program will add a new activity to the ociety's already full slate. It will call for the xpenditure of much time and thought on the part f those who will guide it and, if it is to succeed, or the cooperation of all. A further awareness oming from the meeting is that our county associaons are recognizing more and more new responbilities in fields which are peculiarly their own. he plan to study the means by which a closer tie an be made with these organizations and the State ociety is a step toward greatly strengthening both. he approval of our expanding public relations rogram, expressed by the House, gives recognition f the responsibility to the public which our leaders eel is highly important. This and many other ctivities show that our organization is definitely n the move. However, it becomes plain that, with uch an increasing program, our present budgetary commitments soon must be augmented and that an increase in annual dues seems inevitable. It is difficult to believe that this will be objected to, for a program curtailment is unthinkable at this time.

The Connecticut State Medical Society has come to occupy a place of importance and influence in our social structure. Its relationships with state governing bodies and with many welfare agencies appear hardly to be capable of much improvement. This position has not just happened. It has come about over the years by the unselfish efforts of members of our Society, working in a multitude of professional and civic work. All of these men and women deserve not only our wholehearted support but far more appreciation than we are wont to give. Today more than ever, the State Medical Society is one of the great safeguards of medical practice, beneficial to both doctor and patient. The recent annual meeting shows it to be a progressive and sound organization. We can only keep it so by never forgetting that its life blood is in its membership.

The Voluntary Hospital

The editor of the *Modern Hospital* in his recent address before the Connecticut Hospital Association emphasized with no uncertainty the serious problems that face the greatest hospital system in the world. The voluntary hospital, as we know it, is the result of a community desire to supply an indispensable community need and, like the democracy under which we live, depends for its sustenance and

growth upon cooperative community effort. In considering the importance of hospitals to our way of life we must not forget that, in addition to service for the sick, they offer training opportunities for doctors, nurses, and other professional workers in a field of education which is uniquely their own. Without such opportunities essential clinical training of young physicians would hardly exist. Mr. Sloan also places emphasis on the heavy responsibilities of those who establish hospital policies, namely the trustees or directors. It is on such boards that leadership and proper community representation are of great importance. That there should be a wider representation of the medical profession on such boards is a theme upon which we have made editorial comment before. To say, as has been alleged, that such representation is dangerous in that it tends to create situations of undue political power shows a lack of confidence which is wholly unrealistic. No group of citizens has a greater stake and interest in the efficient operation of the voluntary hospital. Medicine, also, has wise statesmen who have qualities of leadership and who know responsibility. The future of the voluntary hospital depends upon a deeper concern of all members of the community which it serves. It can only be assured by continued cooperative effort.

The Hazards of Retirement

To know how to grow old is the master-work of wisdom, and one of the most difficult chapters in the great art of living.

Amiel's Journal

Anyone who practices medicine for long, with his eyes peeled and his mind open, can hardly fail to develop notions about the peculiarities and performances of human beings that, while not always scientifically demonstrable, may yet contain much more than a modicum of truth. For many years the writer has believed that enforced retirement from either mental or manual work is apt, in a good many people, to be followed by rather speedy death. That other physicians hold the same view is shown in a recent article by Theodore Klumpp* who says: "Those who have seen, as I have, the compulsory retirement of faithful employees who have been working at their jobs for 20, 30, or 40 years to the boneyard by some blind compulsory retirement scheme, know what I am talking about. I believe I understand why so often they die shortly aft retirement."

Discussion of this subject is pertinent at this tir chiefly because of situations frequently emphasiz in recent years, the most important being the i creased expectation of life. As is well known, th has been brought about mainly by the conquest many of the killers of youth, notably such infectio diseases as summer diarrhea, smallpox, diphther and typhoid fever, and by a reduction in the morta ity of other serious infections by modern metho of treatment. It is well known that these perforn ances, along with a declining birth rate, are marke ly increasing the proportion of the middle-aged an old in the population, so that it is estimated that i 1980 over 40 per cent of the population will be 4 years or over and nearly 15 per cent 65 years o over. Furthermore, the tendency of governmenta commercial, and educational agencies to set up com pulsory retirement systems which, incidentally vary considerably in the age at which they regar retirement desirable, is adding an increasing numbe of old, but not necessarily incapacitated, peopl to the leisure class.

We do not desire to discuss the economic aspect of this situation, important though they be, or t consider in any detail the causes of the prematur mortality which affects some of the retired if ou premise is correct. While some are indubitably th victims of latent disease, the main trouble in other may be, as Klumpp suggests, a disturbance of tha normal uniformity or stability of the bodily fune tions which Walter Cannon described as homeo stasis, activated perhaps by an abrupt change in life long habits. Whatever the cause of these deaths may be, an ounce of prevention is still better than a pound of cure, and an important aspect of the problem is whether, and if so how, we can rescue at least some of these old people from a premature death associated with what Richard Steele called "the insupportable labor of doing nothing."

It is perfectly obvious that the mass of the retired is composed of a mixture of individuals of diversified education and manifold capacities, and it should not be forgotten that chronological age is frequently not synonymous with physiological age. It it a matter of observation that a good many of the retired. particularly those from teaching or other professional fields who are still possessed of energy and initiative, succeed in finding reemployment, either as paid or volunteer workers, in some field

*Geriatrics, May-June 1947

which interests them. On the other hand, there is a group whose working life may have been spent in sharply restricted fields and who may not have developed any outside interests. These are the unfortunates, many of whom have never learned even to play, who, when they take a vacation, are restless and dissatisfied until they are back at their regular job.

It has always seemed to the writer that the main trouble with many of the retired was their failure to prepare for their retirement and that, in many instances, the solution to the problem lay in a diversification of interests, not sufficiently time consuming to interfere with a regular occupation, but of such a nature that when obligatory retirement occurred an elaboration of one or more of these extracurricular activities would suffice to keep the retired individual contented. The same problem confronts those who are involuntarily retired from active life by the not always gentle methods of Dame Nature, and who, nevertheless, may still be capable of useful or entertaining activities. All of which adds up to this: that in view of the uncertainty of continued health and the certainty among many of retirement at a definite age, everyone should prepare for old age *during their active years.* Many individuals are quite capable of deciding on their post-retirement activities. Some will need help, and there are already in existence some agencies, such as the Old Age Counselling Agency of San Francisco, which will furnish aid to those who require it. However, to obtain the best results, the problem should be canvassed during the working years.

G. B.

The Physicians Art Exhibit

The Physicians Art Exhibit shown at the annual meeting in Fairfield was a highly creditable demonstration of art as a physician's avocation and in some instances work was shown which compared favorably with that of artists in the professional group. To Doctors Hansell, Jack, Burr, and others, who planned and arranged this first art exhibit by members of our Society, we offer our congratulations. May the new enterprise grow with the years commensurate with the auspiciousness of its birth. According to the catalogue, 15 of our members participated and the media used included oil, etching, sculpture, temepera, water color, wood inlay, and photography. Some 70 items were on exhibit and a comment on certain of these by the editor must be accepted as an expression of personal preference rather than an attempt at a critique of art. Among such items must be mentioned the wood inlay work of Karl T. Phillips. His "The Stop Over" won the Occy-Cystine Prize and was a fine example of excellent workmanship and exactitude. Edward C. Deming's sculpture deserves high praise, also. His portrait bust of Dr. Frederic C. Lewis won the Ernst-Bischoff prize and "Dr. John Homans," another speaking likeness, was given honorable mention. Louise Larimore, who presented New England scenes in tempera and oil showed good rendition, especially in "New England Church." Robert J. Hansell's "Gas Rationing" was a colorful reminiscence of days happily gone by and his inanimate "Objects in Space," received honorable mention. H. Saxton Burr's "Connecticut River" received the Mosby prize, a fine portrayal of a subject long a favorite one with him. The dry points of Jerome Selinger exhibited clean incisive work, always a test of dry point quality. His "Sugar Mill" was especially pleasing. C. W. Sullivan's oil called "Brazil" also attracted this writer. Herbert Thoms received the Lippincott prize for his dry point "Dudley's Barn." J. Nemoitin in "Thawing River" showed a feeling for his subject well translated on canvas. J. Louis Jack received the Ernst-Bishoff prize for the life size portrait of his brother Dr. Gabriel Jack, a likeness certain to be pleasing to the many friends of the late physician. Dr. Freeman's painting of an interior done in oil was highly acceptable. "Dr. Max Climan," a portrait by Walter Grossman, was very favorably commented upon by those who know the subject. His radiogram "Self Portrait" received a deserved honorable mention for its originality and execution. C. W. Perkins' photograph "To My Chalet" was an example of photography which shows why this medium is being widely recognized as one of the important expressions of art. His photograph of a boat on a lake, taken 50 years ago, was a fine platinum print reminiscent of box camera days. The clean color of Irving S. Dichter's "New England Pastorale" deserves mention and the "Still Life—Gourds," by Samuel Friedman, received a merited honorable mention. All in all this was a stimulating and highly acceptable exhibit. It is certain to interest other members who also have art as an avocation and may indeed attract some neophytes to try their hands at this satisfying hobby.

Mr. Robert

"The object of Rules of Order is to assist an assembly to accomplish in the best possible manner the work for which it was designed. To do this it is necessary to restrain the individual somewhat, as the right of an individual, in any community, to do what he pleases, is incompatible with the interests of the whole . . . It is very material that order, decency, and regularity be preserved in a dignified public body." These words of General Henry Martyn Robert appear in the preface to Rules of Order, first copyrighted in 1876. Robert's manual has become recognized as the authority in parliamentary procedure. It is a compendium which, if given more attention by those who preside at the meetings of our medical societies, would not only be greatly helpful in facilitating the business of the meeting but would add a proper dignity to the proceedings. The suggestion has been made that all secretaries of such organizations should have a copy of Robert's Manual, to be loaned to the presiding officer on his election to office, hence this editorial brief. It may be interesting to know that the author of this valuable work was a graduate of West Point, served with distinction in the Civil War, and on his retirement from the Army was Brigadier General Chief of Engineers. General Robert died in 1923 at the age of 86.

Dr. Murdock Appointed to New Yale Council

The appointment of Dr. Thomas P. Murdock, of Meriden, as one of sixty-three professional and business leaders to serve on the newly created Yale University Council was recently announced by President Charles Seymour.

Dr. Murdock will serve on the Committee on the Division of Medical Affairs, one of the council's nineteen standing committees. The primary function of the council, according to President Seymour, will be "to study the major constituent parts and activities of the University at close range, to offer recommendations for their improvement, and develop plans for their support."

Members of the council have been chosen from Yale alumni and other persons from various professional and business groups throughout the country. President Seymour said recently that council members have been selected "for their special fitness to deal with the particular fields of interest to which the committees of the Council will be assigned."

Lucius F. Robinson, prominent Hartford attorney, has been named council president, and Frank D. Ashburn, headmaster of Brooks School, Andover, Massachusetts, vice-president.

The committees of the council, which somewhat resembles Harvard's Board of Overseers, will seek information from all possible sources in their studies of university functions. Based on these studies, the committees will develop plans for betterment of the particular sections of the University to which they are assigned. Once a year each committee shall report its findings and recommendations to the council as a whole, to be approved and transmitted to the president and the University Corporation.

Chairman of the Committee on the Division of Medical Affairs is Reginald G. Coombe, president of the Board of Managers of Memorial Hospital, New York City. Other members include Barclay Robinson, chairman of the Executive Committee of the Hartford Hospital; Robert E. Hunter, Pasadena, California; and Dr. Daniel C. Elkin, Whitehead professor of surgery, Emory University, Georgia.

In addition to medical affairs, committees of the University Council will study the following functions: Public Relations, University Development, Alumni Relations, Division of the Humanities; Division of the Sciences, Division of Engineering, Law School, Divinity School, Music School, Forestry School, Library, Peabody Museum, Publications, Division of the Arts (Drama); Division of the Arts (Painting, Sculpture, Architecture), Art Gallery, Undergraduate Activities, and Athletics.

THESE GAVE

CONTRIBUTORS TO THE BUILDING, MARCH 10 TO MAY 10, 1948

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M. J. C. Allinson, Hamden
David F. Conway, Jr., New Haven
Harry G. Moss, New Haven
Bernhard A. Rogowski, New Haven
Benjamin B. Rosenthal, Milford
Frederick A. Wies, New Haven

New Haven County—*Cont.*

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John C. Yavis, New Haven

Fairfield County

M. H. Eddy, Bridgeport

Hartford County

Florence Marsh, Manchester

New London County

Mario J. Albimonti, Norwich
Maurice R. Moore, Norwich

PROGRESS IN CLINICAL MEDICINE

PSYCHOSOMATIC MEDICINE: THE ETIOLOGICAL APPROACH TO DIAGNOSIS AND THERAPY

CHARLES T. BINGHAM, M.D., *Hartford*

PHYSICIANS in general need a simpler and more dynamic concept of the effects of human emotions on the physiology of the body. The fact that tremendous changes in the body can be caused by emotional tension has been recognized as long as man has studied man and tried to help his fellow. However, the discovery of the microscope, and all that the microscope revealed, gave great impetus to the morphological study of the body and little further interest was shown in a similar study of the mind. The science of pathology became the leader in medicine and the laboratory was its shrine.

The discoveries and hypotheses of Freud sixty years later reawakened interest in mental problems and paved the way for the recent great advances of psychiatry. This meant two important avenues of approach to man's problems had been made—the purely morphological or organic one—easy to see and study—and the functional one—more theoretical and hard to visualize. The bringing of the two sciences—psychiatry and organic medicine—together, has been tremendously retarded by the extreme specialism and narrow-mindedness in each field. The attempt to bridge this gap and popularize it began about thirty-five years ago, but even though the literature has contained thousands of case histories of emotional etiological factors which might produce somatic disorders[1] and of startling accounts of cures affected by psychotherapy, the application of this knowledge has not been widespread. More recently, with the publication of textbooks on psychosomatic medicine[2] and of articles on this subject in the lay and professional periodicals,[3,4,5,6,7,8] there has developed a renaissance of interest in the science of "total" man. I wish in this paper to define and plead for the relative simplicity and tremendous importance of this approach.

Emotional tension develops in all human beings when their aims and ambitions are frustrated, when their hearts' desire is denied, when the energy of their drive in any direction is unsatisfactorily utilized. Fears and anxieties, guilt feelings, resentments, and injured pride all give rise to this energy or emotional tension. If the cause of these fears and frustrations is understood by the human being or if he has insight into the reasons for his conflicts he can usually resolve the difficulty and suffer no ill effect. If, however, the frustration or fear is subconscious, that is, not consciously appreciated by the human being, the tension or conflict which develops can not be resolved, it increases and finally projects itself in the form of psychosomatic complaints. If the underlying causes of these symptoms can be determined by the diagnostician the whole situation *may* be improved. If the physician does *not* understand why his patient has the symptoms he presents, he is faced with the dilemma of:

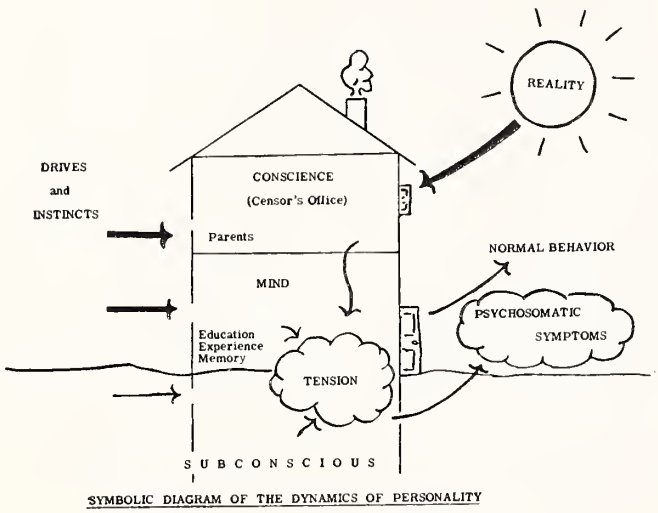
1. Confessing his ignorance, or
2. Prescribing drugs largely on an empirical basis.

The first method is too painful and difficult for the average man to use, particularly if he claims to be a diagnostician and not a surgical specialist. The second method is unsatisfactory for the physician since it causes him to lose confidence in his own ability as a diagnostician and destroys much of his interest in the patient. *Therefore, it is most important that the physician learn to interpret and make use of the multitudinous complaints and bizarre symptoms which beset his patients.*

ANATOMY OF PERSONALITY

In order to interpret these disorders a physician must have a working knowledge of the anatomy of the personality and the mechanisms whereby the mind operates.[9] As we refer to the accompanying diagram (Figure 1) we will see that the mind and the dynamic forces which control it are represented symbolically. If a house represents the total personality the controlling spirit of this house is conscience. Conscience is a censor or overseer trained

by the parents or parent surrogates. The censor's office is on the upper level. The mind, which is schematically represented as working on the ground floor of the house, depends for its growth on the education, experience and memory content which the personality has had since infancy. Any force or urge or instinct which enters the house whether from the side of reality, represented by the sun shining in front of the house, or from the side of the unconscious, represented by arrows driving from the rear, must be investigated and clarified by the use of the mind before or after the censor has passed on it. Normal behavior is an expression of energy transmitted into action after it has gone through the chambers of the personality. This may be represented by an arrow coming from the front door of the house. Reality, symbolized by the sun, is constantly sending its stimuli through the receptive windows of the house. Many of these stimuli are unpleasant. Some of them require that the door to rational behavior be closed. Some of them actually close the door to drives and forces which are very urgent and strong. The resultant conflict of forces or damming up of energy results in inner tension. Some of this tension is on the conscious level in the workroom of the mind. Some of it is at a higher level and concerns a struggle between the mind and the censor or the person's conscience itself. Much of the tension is too painful to be tolerated and is repressed down into the cellar, under-ground, into the subconscious portion of the personality. Wherever tension or conflict exists trouble of some sort ensues. At the highest level we may become depressed and irritable. On the mental level we may become confused, absent-minded and inefficient. Tension at the subconscious or lower level may cause physiological disturbances. These physiological disturbances give rise to somatic or bodily sensations, popularly known as psychosomatic complaints. *Every human being has many of these sensations off and on* during his or her life. No one is immune to them. They represent tension. One of the main reasons why tension expresses itself physiologically is because of the normal mental mechanism known as symbolism.



SYMBOLIC DIAGRAM OF THE DYNAMICS OF PERSONALITY

FIGURE 1

SYMBOLISM

A human mind can only function subconsciously in a symbolic manner. Spoken words and written words have little place in the subsconscious. Symbolism is the major means by which a hidden guilt or a frustrated desire, a subconscious urge or a thwarted drive can express itself. When we are distressed subconsciously by anxiety or anger, by resentment or hurt-pride, tension increases, and the personality finds an outlet for this energy through symbolism.

The physiological responses which are symbolic representations of emotional tension must follow a definite pattern because, if the mind is trying to eliminate tension symbolically, it will, by the very nature of symbolism, do it by the use of symbols which most closely represent the emotion involved. These symbols may well vary in different individuals depending on the association of ideas in their memory content and they must of course pass the censor. If an emotional urge is banned from expression by the censor it must be disguised to get by, and it is up to the diagnostician to strip it of its symbolical clothing and see it for what it really is. However, if we examine a few symptoms and emotions side by side we will see that frequently the pattern is very similar and repeats itself with astonishing regularity.

Crying in a child represents physiological change brought on by many emotions such as guilt, anxiety and fear. Adults do not cry so easily but hay fever is very similar to crying physiologically and also etiologically. Fright in many people causes sweating and trembling, palpitation of the heart, or a catching in the throat. The tremor, tachycardia and other features of hyperthyroidism are the obvious expressions of prolonged anxiety. The heartaches of daily life which are repressed by some people who fear

o face them, lead to tension (spasm) of the coro-ary arteries known as angina pectoris. Disgust with elf or a life situation, hidden gripes or anger find xpression easily in the nausea, anorexia and colicky ains of "nervous" indigestion. The nervous tension aused by resentment and by repression of aggres-ve, hostile tendencies naturally increases muscular nsion and leads to the symptoms of fibro-myositis, rthralgia and non-specific rheumatism.

This symbolism is often called "organ language"[2] nd if symptomatology and personal history are arefully taken in the patient's own words the clue o the diagnosis is often very obvious. "Pain in the eck" usually means that someone or something is ausing the patient to have a muscle spasm of the uchal muscles. This may involve also extrinsic ryngeal muscles and result in aphonia. "Tight band cross the eyes" reveals that the patient is "wearing is halo too tight" and having difficulty satisfying is conscience. "Feeling that my head would burst" s symbolic of extreme nervous tension which hreatens to destroy all peace of mind. "A tightness n the throat" suggests something in the patient's ife he or she cannot swallow. "All gone feeling" nay well mean an anxiety attack brought on by the patient's subconscious inability to solve a situation which prompts the desire to be physically removed rom it. This same mechanism may lead to "fainting pells," a "falling attack" or narcolepsy. "That gets nder my skin" or "irritates me terribly" will lead o a pruritis or dermatitis. "That disgusts me" may e the prime factor inherently responsible for the levelopment of a peptic ulcer. Insecurity and a craving" for love may lead to overeating and besity.

These facts may be stated more clearly as follows: Emotional tension finds its release in symbolically determined physiological changes. Thus the body is removed from its dilemma by means of syncope or sleep, or can show its repressed disgust by vomiting. It can express its hidden hostility in tense (and tender) muscles or reveal its cravings for love (in-security) by hunger pains and satisfy them by over-eating. The causes of the disgust and irritation, guilt and resentment are often deeply seated in the per-sonality. They represent the deeper expressions of what we so glibly imply when we say "I'm dis-gusted with myself" or "mad at myself" or "hate myself." These factors may be hard to find. More obvious influences and causes of conflict are not so important. It is usually those which are subcon-scious, too painful for us to concede even to our conscious minds, which produce symptoms.

ETIOLOGY OF DISEASE

When a study is made of the important factors in a patient's life which lead to tension, anxiety or stress, and when a symbolic outlet for this emotional energy is found by the body in the development of symptoms, it becomes very apparent that the usual concept of the etiology of disease must be reversed.

Instead of:

ORGANIC DISEASE →
PHYSIOLOGICAL DISTURBANCE →
EMOTIONAL CHANGE,

we have:

EMOTIONAL DISTURBANCE →
PHYSIOLOGICAL CHANGE →
ORGANIC DISEASE

This is the concept which must be taken into account if one is going to understand sick human beings.[2,9] It is, of course, obvious that the above process can be written both ways, but in all organic disease we must understand the emotional factors in order to ever fully understand the etiology of what we are trying to treat. How much more disturbed a patient is bound to be when organic disease, with all it implies, is piled on top of the emotional factors which were either wholly or partly responsible for bringing it about. When a patient accepts the organic illness with perfect equilibrium it may become strik-ingly clear that his personality is at least temporarily quite happy with his affliction and may subcon-sciously have helped produce it. When patients are totally unable to accept the illness their insistence against its unreasonableness may even be a cloak for their inner satisfaction. Therefore, in searching for the etiology of any disease or symptom we must listen carefully to the symbolic terms or "organ language" which the patient nearly always uses to explain his troubles to us. Translate this into its most likely symbolic sphere and search out the factors in that sphere. In other words, if he complains of head symptoms, such as migraine, search for unresolved problems of the mind and conscience, conflicts in the highest spheres of man's personality. The accom-panying tabulation (Figure 2) of other syndromes and the symbolically expressed emotions is instruc-tive and may help in our understanding of certain allied organic diseases.

After a survey of these organ spheres in which physiological changes result, in the last analysis,

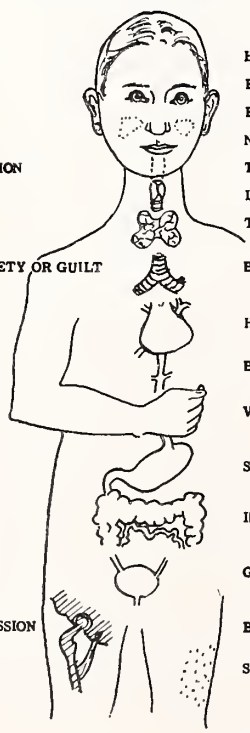
from fear or anxiety,[9] it might be well for all clinicians to consider what an enormous number of organic diseases may be produced by this same mechanism. For example: hypertension and arteriosclerotic cardio-vascular disease; rhinitis with resultant sinusitis and otitis; asthma with resultant chronic bronchitis, emphysema and bronchiectasis; functional dyspepsia with the production of pylorospasm, and cardiospasm, peptic ulcer, perforation and peritonitis; spastic colon with the formation of diverticuli and diverticulitis; spasm of the arteries as in Raynaud's disease, and Buerger's disease with the development of peripheral arteriosclerosis and gangrene. All these and many more conditions probably have their beginnings in emotional tension.

INVOLVEMENT OF DEEP VISCERAL ORGANS

From a review of the ground that has been covered above it seems logical to conclude that any organ in the body can be remarkably changed due to emotional tension. In other words, if the physiology of the skin, heart, thyroid and lungs, the connective tissues surrounding bones and joints and the thin walls of the entire gastrointestinal tract can be affected by an excess of stimuli from psychogenic factors, it seems hardly reasonable to argue that the physiology of more deep-seated organs, such as the liver, pancreas and kidneys, thymus and adrena peripheral nerves and central nervous system shou not be similarly affected. It has long been know that emotional trauma may be followed by t rapid development of diabetes. Why should n chronic nephritis be initiated similarly? Spasm arteries with changes in circulation in these orga may well be symbolic manifestations of inner te sion which follow a pattern as consistently as w have seen to be the case in other organs, such eyes,[10] ears,[11] and muscles.[12] Further observatio and open-mindedness will clarify this very rapidl In fact, recent work[13] on spasm of arterial vesse in the kidneys causing ischemia, degeneration an necrosis of the parenchyma, has been seen to de velop as a result of the shock of injury, mos notably in the so-called "crush syndrome," and ca one say that shock is not primarily due to emotion- to the dreadful anguish of pain and the fearful sigh of mangled tissue? An open mind on the physician' part may soon reveal to him the etiology of many many other obscure conditions.

MINOR PSYCHOTHERAPY

The major psychoses and advanced deep-seate psychoneuroses require the services of highl trained and certified psychiatrists, but it has beer



EMOTIONAL TENSION ETIOLOGICAL FACTORS	SPHERE of SYMBOLIC PHYSIOLOGICAL CHANGE	EXAMPLES of TYPICAL PSYCHOSOMATIC DISORDERS	POSSIBLE RESULTANT ORGANIC DISEASE
MENTAL CONFLICT, UNRESOLVED PROBLEMS	HEAD	MIGRAINE	CEREBRAL ARTERIOSCLEROSIS
ANXIETY CONCERNING VISUAL STIMULI	EYES	CENTRAL ANGIOSPASTIC RETINOPATHY	BLINDNESS
ANXIETY CONCERNING AUDITORY STIMULI	EARS	PSYCHOGENIC DEAFNESS	MENIERE'S DISEASE
GUILT, HURT PRIDE	NOSE & SINUSES	ALLERGIC RHINITIS	CHRONIC SINUSITIS
INABILITY TO TOLERATE OR SWALLOW A SITUATION	THROAT	GLOBUS HYSTERICUS	MALNUTRITION
INABILITY TO EXPRESS AN EMOTION	LARYNX	APHONIA	CHRONIC LARYNGITIS
CHRONIC FEAR	THYROID	HYPERTHYROIDISM	EXOPHTHALMIC GOITRE
CHOKING DOWN OF RESENTMENT, HATRED, ANXIETY OR GUILT	BRONCHI	ASTHMA	EMPHYSEMA
FEAR, INSECURITY, WORRY OVER LOVED ONES	HEART	ANGINA PECTORIS	CORONARY ARTERIOSCLEROSIS
REPRESSED ANGER, HOSTILITY OR AGGRESSION	B. P.	HYPERTENSION	HYPERTENSIVE C-V DISEASE
ANXIETY, INSECURITY, GUILT	VASOMOTOR	RAYNAUD'S DISEASE	GANGRENE
INSECURITY, DISGUST WITH LIFE SITUATION	STOMACH	FUNCTIONAL DYSPEPSIA	PEPTIC ULCER
IRRITABILITY, GRIPING, INSECURITY	INTESTINES	IRRITABLE COLON	ULCERATIVE COLITIS
SEXUAL FRUSTRATION, GUILT OR FEAR	G. U.	♂ IMPOTENCE ♀ FRIGIDITY	STERILITY
REPRESSED RESENTMENT, HOSTILITY OR AGGRESSION	MUSCLES BONES & JOINTS	"FIBROSITIS"	CHRONIC ARTHRITIS
IRRITATION, ANGER, SHAME, INSECURITY	SKIN	URTICARIA	CHRONIC ECZEMA

FIGURE 2

nceded by these specialists that from 75 to 90 per nt of emotional disorders are seen in the practice the general practitioner and must be handled by m or by internists.[3,4,7] The general medical man d internist must give the treatment in the psychomatic disorders most of the time if it is to be given all. Sufficient psychiatrists are just not available r minor psychotherapy.

What is minor psychotherapy? Can it be outlined simple terms? Since psychotherapy of the minor pe and diagnosis of the psychosomatic disorders hand in hand the treatment can not be separated m the diagnosis. Therefore the problem of treatnt should be approached through the process of king an accurate etiological diagnosis. The following suggestions may therefore be made:

1. *Listen carefully* to the patient's own story as describes his symptoms, sensations and ideas as their etiology. He will always use organ language d we must be alert to every clue he gives us.

2. Take a careful and complete, painstaking medil history followed by an equally careful, comete and painstaking (but tactful) search for psyogenic factors in the:

A. Family history and home background.
B. Childhood history.
C. Education and occupational history.
D. Marital and sexual history.

3. Now that you know the patient's background, e type of conscience or censor he possesses, the ols his mind has to work with and the painful periences which he has suffered, make use of *mbolism* to aid you in understanding what is king place in the patient's mind to cause his mptoms.

4. When you understand the patient's personality d his conflicts and his symptoms give him *an objective viewpoint towards his conflict*, what has en called "*a sense of mastery over the conflict.*"

5. Elucidate the nature of his conflict and how it fects him, *only in small doses*, depending on his sight and tolerance. The more emotionally mature e is the more he will be able to accept.

6. Reassure him; use suggestion; listen patiently his problems; stimulate his interests in diversions and other fields; but remember, your aim is to *strengthen his character by the self-understanding which leads to self-confidence.*

RESULTS OF THERAPY

Every internist and general medical practitioner who has seen the remarkable results which therapy as outlined above can give in many baffling disorders, will be well repaid for the time he spends on an individual patient. The elimination of urticarial and acute anxiety attacks, the amelioration of asthmatic episodes and dermatoses, the reduction of chronic dyspepsia and "ulcer" symptoms, to say nothing of the improvement of neuritic pains, chronic rheumatism, "fibrositis" and many other tension states, will make the daily life of the medical man not only much more gratifying but infinitely more interesting. The day is dawning when medical men will no longer have to say "we have no idea what the cause of this condition is."

BIBLIOGRAPHY

1. Dunbar, H. F.: Emotions and Bodily Changes. A Survey of Literature on Psychosomatic Inter-relationships 1910-1933. Second Edition Columbia Univ. Press. 1938.

2. Weiss, E., and English, O. S.: Psychosomatic Medicine. W. B. Saunders Co., 1943.

3. Waggoner, R. W.: Psychoneurosis in General Practice. J.A.M.A. 134:779, 1947.

4. Barr, D. P.: The Responsibility of the Internist. Ann. Int. Med. 27: (O.S., Vol. XXX), 195, 1947.

5. Wearn, J. T.: Functional Disease. J.A.M.A. 134:1517, 1947.

6. Strecker, E. A.: Psychosomatics. J.A.M.A. 134:1520, 1947.

7. Menninger, W. C.: The Problem of the Neurotic Patient. Ann. Int. Med. 27: (O.S., Vol. XXXI), 487, 1947.

8. Darley, W.: Relationship of Psychiatry to Problems of Medical Care. The Diplomate. 19:179, 1947.

9. Groom, D.: Some Applications of Psychiatry in General Medicine. J.A.M.A. 135:403, 1947.

10. Harrington, D. O.: Ocular Manifestations of Psychosomatic Disorders. J.A.M.A. 133:669, 1947.

11. Truex, E. H., Jr.: Psychogenic Deafness: Conn. State Med. J. 10:907, 1946.

12. Weiss, E.: Psychogenic Rheumatism. Ann. Int. Med. 26: (O.S., Vol. XXX), 890, 1947.

13. Corcoran. A. C., and Page, I. C.: Crush Syndrome: Post Traumatic Anuria. J.A.M.A. 134:436, 1947.

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SECRETARY'S REPORT, HOUSE OF DELEGATES, APRIL 27, 1948

Mr. President and Members of the House of Delegates:

It has become a pleasant commonplace each year to note striking increases in membership in the Society and the largest gain ever reported can be given for the year just past. On page eight of the Agenda you will find a statistical analysis of the membership changes. This shows a net gain of 146 for the year with a total membership of 2,356 on April 1, 1948. The elections at the annual meetings of the county associations during this month are not included and these total approximately 100 more, so that as of today our membership is about 2,450, a figure which I think the most optimistic of us would not have anticipated a few years ago.

The activities of the Society continue to expand and the demands that are quite properly made on the office staff and machinery are constantly increasing. No one wishes to hold back wise and productive expansion of our activities, but I must inform you, and I do it with reluctance, that our present office facilities are entirely inadequate and we are constantly handicapped by lack of space. Two members of the executive staff work in an office that is actually rented by the State of Connecticut for housing of the Medical Examining Board. This arrangement was entered into originally with the idea that it would be temporary and I am not sure how well it would be received by state authorities if it was understood to be a permanent arrangement. I believe it is my duty to inform you at this time that we have just about reached the limit of operation in our present office and if a change to more adequate space is not possible, we must limit the things we undertake to do.

Policy making and planning for an organization of this kind must be done by committees and our effectiveness in the many fields in which we engage is measured almost exactly by the efficiency with which committees work and guide us. It is proper I think that this House knows the operation of our important committees, their productiveness and their shortcomings, if they exist.

Too much cannot be said in praise of the Committee on Public Health, the Committee on Industrial Health and the Committee on Medical Care of Veterans. These committees operate autonomously with broad conception of their importance and they are constant agents in extending the usefulness of the Society both to its members and to the community in which we live.

Many of us have been concerned with developments which are bringing hospitals to engage more and more in the practice of medicine. This matter is causing no small disturbance throughout the country, so much so that a special committee of the American Medical Association has been appointed to study the matter. Quite properly we believe that the Committee on Hospitals of this Society should have concerned itself with this topic and I hope that the frequent conferences which have been held in times past by our Committee on Hospitals with a representative body of the Connecticut Hospital Association can be revived promptly and effectively. I have reasonable assurance that such a permanent conference plan will be welcomed by the Hospital Association and I believe, this House should encourage this action. The Committee on Hospitals needs vigorous reactivation.

Connecticut has moved ahead rapidly in the field of cancer interest. There are three agencies properly concerned in this question, they are the State Medical Society, State Department of Health and the Connecticut Cancer Society. Each one of these is moved by the highest intent and there is a common objective for them all. Their activities have

een beneficial to the people of Connecticut in ifferent ways. They have aroused the interest of ntelligent laymen in protecting themselves against ancer. They have stimulated physicians to increase eir knowledge of cancer. They have extended lay ducation and service programs to a widening circle f the population, providing a better understanding f the cancer problem and measures necessary for s more adequate control. However, I believe, the me has come when there should be recognized eadership in this great cancer program, there should e some means to correlate all the efforts of these hree organizations and I hope you will agree with ne that leadership should be accepted by our ociety through its Committee on Tumor Study. I ropose that the Committee be asked to plan a long ange integrated program in conference with repre-entatives of the other agencies in the cancer field.

The Committee on Military History of the ociety has been discontinued by vote of the Coun-il. This Committee was created before World War II ended with the idea of producing a history f the Society's participation in the war. At once, a nethod was set up to gather military biographies of ur members and information thus received is of ncreasing value and nearly complete. The first of hese biographical sketches have already been pub-ished in the State JOURNAL. As the happier events f civil life effaced war recollection, interest in this istory waned and the early plans of the Committee eemed too elaborate. Finally, it was deemed best hat the project be largely given up and that what vas to be done should be carried on by the editors f the JOURNAL and the office of the Executive ecretary.

Comment has already been made concerning our tudent membership program. Connecticut did riginate this idea and it is to our credit. However, am quite sure we could extend our usefulness to hese young men entering medicine and I wish to ropose that a Committee on Student Membership ctivities be created. It would be the purpose of this ommittee to provide ways in which the Society night be in continuous contact with its student nembers, familiarize these members with the activi-ies and purposes of the Society and arrange occa-ional meetings in those schools where there are a air number of Connecticut students.

Many Societies have the good custom of espe-ially recognizing members of fifty years standing. Usually, there is a graceful ceremony at each annual meeting and appropriate insignia given to these members and, of course, under our By-Laws they are exempt from payment of dues, if they wish to be. I would like to recommend that the Committee on Honorary Members and Degrees be asked to plan such a project for us.

Whether the nation is following the advice to exercise reasonable common sense and prudence which Mr. Churchill gave Great Britain in the early thirties and which went unheeded or whether we are developing what Mr. Secretary Marshall has called "respectable might," it is a fact that for the third time in our lifetime America is getting ready for war. These preparations will involve medicine more than ever, both in planning and in operation, particularly in the protection of civilians.

It had not been publicized much but a civil defense unit has been established directly under the Secretary of Defense, Mr. Forrestal, and the secretary of this section in the Office of the Secretary of Defense is co-equal with the Army, Navy and Air secretaries. Civil defense has become as important as the combatant forces in present war plans. The American Medical Association has a Council on National Emergency Medical Service and at a conference called by this Council at the request of the Army, Navy and Air Forces in Chicago about three weeks ago, the part that medicine will have to play was presented and can be divided in three parts. First, it is generally accepted that the Selective Service will be reactivated and the medical profession will again be expected to render technical help in its operation. Second, physicians will be needed for the Armed Forces and it is quite likely that a classification board such as the Procurement and Assignment Service will be created at the state level to determine availability and priority for physicians in an effort to allocate medical personnel fairly between the Armed Forces and the civilian population. Third, is the development of methods for the protection of the civilians in the event of military disaster. It has already been suggested by the American Medical Association that state medical societies create committees to accomplish all this and to cooperate with other public and private agencies in developing state plans. It is to be expected that the Secretary of Civil Defense in the near future will issue directives to the state governments to create state war councils again. This Society must be ready to do its part.

We will be fortunate, indeed, if we are able to

find another who can do the job that George Smith did a few years ago, his accomplishments were known across the country and his plans served as models for many other communities. The person who becomes the chairman of a war plans committee of this Society, if it is created, will undoubtedly be the medical advisor to the war council and must be equipped with intelligence, administrative ability and time, and be willing to accept great responsibility.

It seems incredible that such a proposal should have to be made at this time but, I recommend to this House that it instruct the Council to take all necessary steps in the defense program in cooperation with the federal government and other states and to further instruct the Council to appoint a Committee on Emergency Medical Service which will join with other public and private agencies in the development of a civilian defense plan for the State of Connecticut. I hope we can conclude a year from now that this step was unnecessary, but I am sure now it must be done.

I suppose most of you realize the time and thought that is given to your affairs by the members of the Council, particularly a small group which has been willing to accept unusual responsibility. Included in this group is Dr. Miller, who leaves the Council after this meeting. We shall all miss him and I particularly because he has been a member of the Council all of the time I have been on it and we have worked closely together. No one can measure how much has been given to Connecticut medicine by Jim Miller and his team mate Tom Murdock. It is unfortunate that the Society does lose Dr. Miller's service in an important position. To all of these people, you owe a great debt and I want to express my own appreciation of their continuous cooperation and understanding.

Finally, I wish to speak in praise of the staff in the secretary's office which continues to give generous service in your interest. In addition to her already busy schedule Miss Mooney has willingly accepted the new responsibility of representing the Society in its many valuable contacts with voluntary health and welfare agencies and has moved us into an important position in that field. She is by training and experience highly qualified for this function which no alert medical society can disregard, and her abilities have been recognized by an invitation to participate in the Section on Community Agencies in the National Health Assembly in Washington next week. Mr. Burch, while nominally under the direction of the Committee on Public Relations works constantly in close cooperation with the State office and the JOURNAL and has extended our public relations in many new and useful ways. Last summer the stenographic staff was reduced by the half time services of one person when the clerk to the Medical Examining Board became a full time employee of the Board. This added to the work done by the two stenographers employed by the Society and an additional clerk typist is needed but there is not space to put anyone else. In an operation such as ours and a small staff, it is neither practical or possible to departmentalize and segregate duties, so all of us try to know how to do almost all the things we do and there are frequent frank discussions of our activities and ways to improve them. This makes for the best of understanding and team work which is an important factor in the successful operation of your affairs and I wish to express my gratitude to this staff which works so loyally with me.

This report could be extended almost without limit, there are so many details that could be discussed. You will hear other reports during the day and I hope from them you will arrive at a better understanding of just what is the Connecticut State Medical Society, what it does for the public, the profession and for you as an individual. Some of you may have learned many of these things in the exacting school of experience, by rolling up your sleeves and working for the Society, others may stay in the middle, accepting the Society on faith alone, satisfied with its purposes, and content to let it go its way so long as it doesn't bother you much. Still others may be unwilling to concede the need for anything but the quiescent cloistered organization of the past. All of you should be enlightened by the reports that you will hear and the business that is done today.

The details of our annual meeting are becoming more and more complex and many willing workers are involved in their arrangement. This year you are particularly indebted to the Program Committee under the chairmanship of the President-elect, Dr. Harvey, and the Fairfield County Committee led by the tireless Joe Howard and I know I may express your gratitude to them.

RECOMMENDATIONS IN THE REPORT OF THE SECRETARY

1. Establish conference committee with representatives of the Connecticut Hospital Association.

2. Request Committee on Tumor Study to develop a long range plan for a cancer program in Connecticut.

3. Establish a Committee on Student Membership.

4. Request Committee on Honorary Membership and Degrees to outline a plan to recognize members of fifty years' standing.

5. Authorize the Council to take all necessary steps in defense program and to appoint a Committee on Emergency Medical Service.

Meetings Held During May

Thursday, May 6, 3:30 P. M.
Committee on Public Health

Thursday, May 13, 4:30 P. M.
Committee to Study the Workmen's Compensation Laws

Tuesday, May 18, 3:30 P. M.
Council of the Society

Wednesday, May 19, 7:00 P. M.
Committee on Industrial Health

Thursday, May 20, 4:30 P. M.
Special executive meeting, Connecticut Medical Examining Board

Monday, May 24, 5:00 P. M.
Committee on Cooperation with the Yale School of Medicine, Graduates Club

Wednesday, May 26, 4:00 P. M.
Committee to Study Maternal Mortality and Morbidity

Unless otherwise indicated, meetings of committees of the Society are held at the Society office.

NEW MEMBERS ELECTED AT THE ANNUAL METINGS OF THE COUNTY ASSOCIATIONS

Fairfield County

Louis A. Aube, Bridgeport
Malcolm Boshnack, Stamford
Benjamin W. Bullen, Greenwich
S. Farnum Coffin, Jr., Darien
Herbert Conway, Stamford
Frank G. Elliott, Jr., Bridgeport
David H. Fogel, Stamford
Anthony D. Intriere, Greenwich
Thomas L. Ippolito, Norwalk
Eli Bolton Ives, Bridgeport
E. Philip Kemp, Fairfield
Nathaniel Kenigsberg, Bridgeport
Henry V. Kogut, Bridgeport
Warren Lane, Darien
Abraham T. Levine, Cos Cob
Aaron Levinsky, Bridgeport
George M. MacKee, Stamford
Mario J. Mancinelli, Stamford
Allen M. Margold, South Norwalk
Patrick T. McIlroy, Danbury
David Nagourney, Bridgeport
Abbott A. Newman, Bridgeport
Else Pappenheim, Springdale
Frank J. Raffaele, Old Greenwich
Robert D. Russo, Bridgeport
Eugene H. Walzer, Bridgeport

Windham County

Leo LaPalme, Putnam
Walter Rowson, Jr.,
North Grosvenordale
Bruce Valentine, Abington

Hartford County

Ronald S. Beckett, Hartford
Harry Bellach, New Britain
Dorothy W. Brockway, Bristol
John Carangelo, Hartford
Ludmil A. Chotnowski, Kensington
Milton J. Cole, Hartford
William A. Donnelly, Hartford
William A. Ellis, Hartford
Kevin J. Fay, Hartford
*Harold A. Gross, Chicopee Falls, Mass.
William H. Horton, Hartford
Walter F. Jennings, Hartford
Raymond G. Mainer, New York
Nicholas A. Mastronarde, Hartford
Donald R. Morrison, West Hartford
Thomas P. Mullaney, Jr., Windsor Locks
John O'L. Nolan, Hartford
Peter J. Pizzi, Manchester
Joseph N. Russo, Hartford
Stewart P. Seigle, East Hartford
Norris P. Swett, East Hartford
Charles F. Von Salzen, Hartford
Lloyd P. Williams, Hartford
Samuel Wolfson, New Britain
Leon W. Zimmermann, Hartford

Middlesex County

Sanford W. Harvey, Middletown
Clarence W. Harwood, Middletown
James J. Kidney, Clinton
Paul I. Yakovlev, Middletown

Litchfield County

Maurice H. Bisharat, Torrington
George A. Fowler, Sharon

New Haven County

Jerome Beloff, Meriden
A. Joseph Cappelletti, Waterbury
John O. Catalan, New Haven
Michael M. Devinis, Waterbury
Salvatore F. DiLorenzo, Waterbury
George H. Dickinson, Meriden
Hugh L. Dwyer, Jr., New Haven
Malcolm M. Ellison, New Haven
William W. Engstrom, New Haven
Richard W. Finner, New Haven
John B. Flynn, Meriden
Ralph Gancher, Waterbury
Fred C. Green, New Haven
Joseph E. Fitzpatrick, Jr., New Haven
Herman R. Greenhouse, New Haven
William F. Hillier, Jr., New Haven
Arnold H. Janzen, New Haven
John J. Kennedy, Jr., New Haven
Frank E. Lach, New Haven
Herbert D. Lewis, New Haven
Theodore R. Lovelace, Waterbury
Stanley T. Michael, New Haven
Richard J. Ohman, Waterbury
Louis Olore, Waterbury
Joseph P. Shea, Jr., Milford
John K. Shearer, Waterbury
Lyman M. Stowe, New Haven

New London County

Harold W. Duennebier, Niantic
Louis Guss, Norwich
James D. Sawyer, Jewett City

*In military service

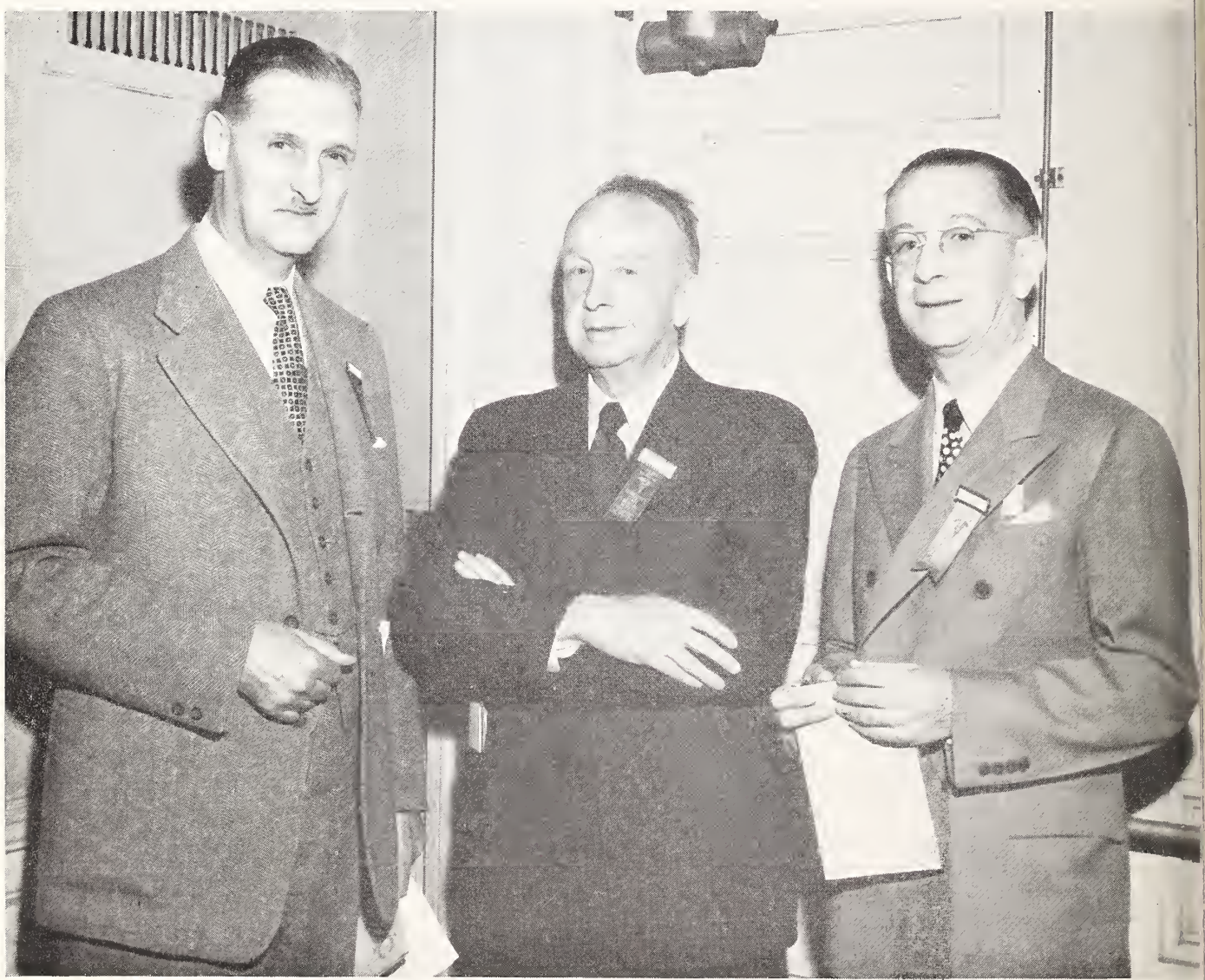
156TH ANNUAL MEETING

The 156th annual meeting of the State Medical Society, held at the Roger Ludlowe High School, Fairfield, on April 28 and 29, was attended by approximately one thousand Connecticut physicians.

The annual banquet, a highlight of the two-day session, brought more than 400 physicians and their wives to the Stratfield Hotel in Bridgeport to hear addresses by Governor James C. Shannon and Edward L. Bortz, president of the American Medical Association.

A notable accomplishment during the meeting was the organization of the Connecticut Diabetes Association, an affiliate of the American Diabet Association. Elected president of the new organ zation was Barnett Greenhouse of New Have Burdette J. Buck, Hartford, was elected first vic president; Anthony J. Cipriano, New Haven, secon vice-president; and John J. Dobkins, Stamfor secretary.

Another new organization formed during th meeting was the Connecticut Physicians Art Ass ciation, which held its first annual exhibit as special feature of the two-day gathering. The fift nine entries in the exhibit included oil painting



Dr. Samuel C. Harvey, new president of the State Medical Society, center, discusses medical affairs with Dr. James R. Miller, retiring president, left, and Dr. Cole B. Gibson, treasurer, at the Society's 156th annual meeting, held in Fairfield on April 28 and 29

water colors, etchings, photographs, and sculpture. The association plans to elect officers soon, and to hold public exhibitions in several sections of the state.

A significant indication of the growing importance of the Home Town Medical Care Plan for Connecticut Veterans was the installation near the registration desk of a special information center for physicians. Arranged by the Society's Committee on Medical Care of Veterans under the chairmanship of Samuel B. Rentsch of Derby, the center was operated by Samuel A. Schuyler, chief medical officer of the Hartford Regional Office of the Veterans Administration, and Rocco Vernile, medical administrator. A considerable number of inquiries were received at the center during its two days of operation.

Attention given the meeting by the press this year was far in advance of previous meetings. Six newspaper reporters and photographers were admitted to the clinical sessions, and a number of telephone requests for information were received from city newspapers and from the newspaper wire services.

At the conclusion of the meeting Samuel C. Harvey, president of the Society, expressed appreciation in the pages of the *Fairfield News*, community newspaper, for the hospitality shown visiting physicians by Fairfield residents. He expressed particular thanks to the Board of Education, to members of the school staff for their untiring efforts to make the meeting a success, and to members of the police and fire departments for their excellent services.

As always, a primary concern of the committee members who plan an annual meeting is to see whether everything operates smoothly, once the facilities have been provided. The annual meetings of the Society have now grown to such dimensions that the responsibilities of planning and operation are tasks of considerable proportions. From this viewpoint the Fairfield meeting proved an outstanding success. The careful preparations made by the committee on arrangements under the chairmanship of Joseph H. Howard of Bridgeport resulted in two days of highly efficient operation. Many favorable comments were received from physicians attending the sessions, and enthusiasm for the excellence of the program arranged by a committee headed by Samuel C. Harvey was evidenced throughout the meeting.

The House of Delegates

*The President of the Society
*The President-Elect of the Society
*The Executive Secretary of the Society
*The Treasurer of the Society *The Editor of the JOURNAL
*Thomas P. Murdock, Delegate to the American Medical Association
*Joseph H. Howard, Delegate to the American Medical Association

COUNCILORS

*Berkley M. Parmelee, Fairfield
*C. Charles Burlingame, Hartford
*Floyd A. Weed, Litchfield
*Harold E. Speight, Middlesex
*Herbert Thoms, New Haven
*George H. Gildersleeve, New London
*Charles T. LaMoure, Tolland
*Karl T. Philipps, Putnam

ELECTED DELEGATES

FAIRFIELD COUNTY

*George A. Buckhout, Bridgeport
George R. Cody, South Norwalk
*Cornelius S. Conklin, Bridgeport
*Nicholas E. Creaturo, Bridgeport
*Ward B. DeKlyn, Danbury
George R. Eckert, Danbury
*John G. Frothingham, New Canaan
*James D. Gold, Bridgeport
*James V. Halloran, Greenwich
*Kirby S. Howlett, Jr., Shelton
*Daniel F. Keegan, Bridgeport
*Robert W. Nespor, Westport
*Morris P. Pitock, Bridgeport
*John J. Scanlon, South Norwalk
*Arthur C. Smith, Danbury
*Jay E. Starrett, Stamford
*Oliver L. Stringfield, Stamford

HARTFORD COUNTY

*Ettore F. Carniglia, Hartford
Armanno W. Ciccarelli, Bristol
S. Paul Coates, Suffield
*James R. Cullen, Hartford
Benjamin B. Earle, Glastonbury
*John N. Gallivan, East Hartford
*Isador S. Geeter, Hartford
Harvey B. Goddard, East Hartford
*George M. Gura, Southington
*George A. F. Lundberg, South Manchester
*Donald J. McCrann, Hartford
*Philip J. Moorad, New Britain
Maxwell O. Phelps, Hartford
*William F. Storms, Wethersfield
*James E. Stretch, Simsbury
*Alfred B. Sundquist, Manchester
*William J. Watson, New Britain

Names checked * were present.

Benjamin B. Whitcomb, Hartford
*W. Holbrook Lowell, Hartford
*Charles T. Schechtman, New Britain
*Dewey Katz, Hartford

Litchfield County

*Richard I. Barstow, Norfolk
*Thomas J. Danaher, Torrington
*John F. Kilgus, Litchfield

New Haven County

*Courtney C. Bishop, New Haven
*Robert B. Boyd, Wallingford
*Jachin B. Davis, New Haven
*William J. Dennehy, New Haven
*Christopher E. Dwyer, Waterbury
*William Finkelstein, Waterbury
*John H. Foster, Waterbury
*Arthur J. Geiger, New Haven
*James A. Gettings, New Haven
*William E. Hall, Meriden
*Harvey Katz, New Haven
*Robert H. Jordan, New Haven
*Irving Katz, Meriden
*M. Hemingway Merriman, Waterbury
*Samuel Spinner, New Haven
*Israel S. Otis, Meriden
*Samuel B. Rentsch, Derby
*J. Harold Root, Waterbury
*Walter I. Russell, New Haven
*A. Lewis Shure, New Haven
*Herbert Thoms, New Haven

Middlesex County

*Willard E. Buckley, Middletown
*Jessie W. Fisher, Middletown
*Norman E. Gissler, Middletown

New London County

*Mario J. Albamonti, Norwich
*Edmund L. Douglas, Groton
*Albert C. Freeman, Norwich
*Thomas Soltz, New London

Tolland County

Wendelin G. Luckner, Stafford Springs

Windham County

*Brae Rafferty, Willimantic
*William Mac Shepard, Putnam

Officers and Committees Elected by the House of Delegates, 1948-1949

President	Samuel C. Harvey, New Haven
President-Elect	Charles H. Sprague, Bridgeport
First Vice-President	Moses Margolick, Putnam
Second Vice-President	Jessie W. Fisher, Middletown
Treasurer	Cole B. Gibson, Meriden
Executive Secretary	Creighton Barker, New Haven
Editor of the Journal	Stanley B. Weld, Hartford

Two Delegates and Two Alternates to the Americ Medical Association—for the term January 1, 19 to December 31, 1950

Creighton Barker, New Haven
Alternate: W. Holbrook Lowell, Jr., Hartford
Joseph H. Howard, Bridgeport
Alternate: Oliver L. Stringfield, Stamford

Program Committee: A member for a term of three years Harris B. Shumacker, Jr., New Haven—so that t committee will consist of:

Carl E. Johnson, New Haven, *Chairman*
Maurice T. Root, Hartford
Harris B. Shumacker, Jr., New Haven
Associate Member: Ira V. Hiscock, New Haven

Journal Editorial Board: A member for a term of fo years—Frank S. Jones, Hartford—so that the boa will consist of:

Herbert Thoms, New Haven
Paul P. Swett, Bloomfield
Benjamin V. White, Hartford
Stanley B. Weld, Hartford
Frank S. Jones, Hartford
Associate Member: Harold S. Burr, New Haven

Committee on Postgraduate Education

Courtney C. Bishop, New Haven, *Chairman*
Harold A. Bergendahl, Norwich
Bliss B. Clark, New Britain
Harvey B. Goddard, East Hartford
John C. Leonard, Hartford
Herbert Thoms, New Haven
William R. Willard, New Haven
Associate Member: C. N. H. Long, New Haven

Committee on Public Policy and Legislation:

Fairfield County, John G. Frothingham, New Canaa
Hartford County, James R. Cullen, Hartford
Litchfield County—W. Bradford Walker, Cornwall
Middlesex County, Richard F. Grant, Cromwell
New Haven County, Charles T. Flynn, New Haven
New London County, Edmund L. Douglass, Groton, *Chairman*
Tolland County, William Schneider, Rockville
Windham County, William S. Maurer, Willimantic
President of the Society
Executive Secretary of the Society
Delegates to the American Medical Association

Committee on Honorary Members and Degrees: A mem for a term of three years—James R. Miller, Hart ford—so that the committee will consist of:

Joseph H. Howard, Bridgeport, *Chairman*
Cole B. Gibson, Meriden
James R. Miller, Hartford

Committee on Medical Examination and Medical Educa tion: A nomination to the Connecticut Medica Examining Board—one member for a term of fiv

years commencing January 1, 1949, to succeed Thomas P. Murdock—John H. Bumstead, New Haven—so that the board will consist of:

John D. Booth, Danbury
George M. Smith, New Haven
Wilmot C. Townsend, Hartford
Louis P. Hastings, Hartford
John H. Bumstead, New Haven

OMMITTEE ON HOSPITALS: Two members for a term of three years—Samuel M. Atkins, Waterbury, and Maxwell O. Phelps, Hartford—so that the committee will consist of:

William H. Curley, Bridgeport, *Chairman*
James C. Fox, Hartford
Albert W. Snoke, New Haven
Harold W. Wellington, New London
Samuel M. Atkins, Waterbury
Maxwell O. Phelps, Hartford

OMMITTEE ON INDUSTRIAL HEALTH

C. Frederick Yeager, Bridgeport, *Chairman*
Preston N. Barton, Bristol
Ronald F. Buchan, New Haven
Clarence H. Cole, Waterbury
Bernard S. Dignam, Thompsonville
John N. Gallivan, East Hartford
Albert S. Gray, Hartford
Martin I. Hall, Bristol
Robert T. Henkle, New London
Reinhold F. Hertzberg, Stamford
Richard J. Hinchey, Waterbury
Andrew J. Jackson, Waterbury
John F. Kilgus, Litchfield
Robert P. Knapp, Manchester
Arthur B. Landry, Hartford
Jerome A. L'Heureux, Meriden
Daniel F. Levy, New Haven
Eugene F. Meschter, Stamford
Philip J. Moorad, New Britain
Frank T. Oberg, Bridgeport
Israel S. Otis, Meriden
Crit Pharris, Glastonbury
Arthur A. Tower, Meriden
Paul W. Vestal, New Haven
Ellwood C. Weise, Bridgeport

OMMITTEE ON PUBLIC HEALTH

Maurice J. Strauss, New Haven, *Chairman*
Donald A. Bristoll, New Britain
John W. Buckley, Bridgeport
Howard S. Colwell, New Haven
Clair B. Crampton, Middletown
Gilbert R. Hubert, Torrington
Joseph I. Linde, New Haven
Douglas Lindsey, New Haven
William H. McMahon, South Norwalk
L. Rogers Morse, Hartford
Luther K. Musselman, New Haven
Karl T. Phillips, Putnam
Oliver L. Stringfield, Stamford
James M. Sturtevant, New London
Carl L. Thenebe, Hartford
William A. Wilson, Hartford
J. Harold Root, Waterbury

Associate Member: F. Lee Mickle, Hartford

COMMITTEE ON PUBLIC RELATIONS

C. Charles Burlingame, Hartford, *Chairman*
Thomas J. Danaher, Torrington
Frederick B. Hartman, New London
Milton L. Lieberthal, Bridgeport
A. Lewis Shure, New Haven
Maurice J. Strauss, New Haven
Charles C. Wilson, New Haven
C. Frederick Yeager, Bridgeport

Associate Member: Howard W. Haggard, New Haven

COMMITTEE ON TUMOR STUDY

Allan J. Ryan, Meriden, *Chairman*
Robert R. Agnew, Norwich
Irving B. Akerson, Bridgeport
John D. Booth, Danbury
Donald A. Bristoll, New Britain
Willard E. Buckley, Middletown
Gerard M. Chartier, Danielson
George P. Cheney, New London
Harold M. Clarke, New Britain
Joseph O. Collins, Waterbury
A. Nowell Creadick, New Haven
Thomas J. Danaher, Torrington
Edward W. Foster, Meriden
Matthew H. Griswold, Hartford
Carl C. Harvey, Middletown
Louis P. Hastings, Hartford
Joseph H. Howard, Bridgeport
Rolf E. Katzenstein, Meriden
Russell A. Keddy, Stamford
Ralph E. Kendall, Hartford
Kenneth K. Kinney, Willimantic
Averill A. Liebow, New Haven
Gustaf E. Lindskog, New Haven
Christie E. McLeod, Middletown
Philip G. McLellan, Hartford
William Mendelsohn, New Haven
Lincoln Opper, Torrington
Edward J. Ottenheimer, Willimantic
Ashley W. Oughterson, New Haven
Berkley M. Parmlee, Bridgeport
Karl T. Phillips, Putnam
Douglas J. Roberts, Hartford
Louis G. Simon, Norwalk
E. Myles Standish, Hartford
Herbert Thoms, New Haven
Frank Turchik, Bridgeport
Donald B. Wells, Hartford
President of the Connecticut Cancer Society
State Commissioner of Health

Delegates to State Societies and Special Societies for the Term of July 1, 1948 to June 30, 1949

Maine:
Stanley B. Weld, Hartford
Harold F. Morrill, Waterbury

Massachusetts
Robert A. Goodell, Hartford
Wilder Tileston, New Haven

New Hampshire:
George H. Gildersleeve, Norwich
Thacher W. Worthen, Hartford

New Jersey:
Oliver L. Stringfield, Stamford
Roger Terkuile, Bridgeport

New York:
Samuel C. Harvey, New Haven
James R. Miller, Hartford

Rhode Island:
William J. H. Fischer, Milford
William Mac Shepard, Putnam

Vermont:
Orpheus J. Bizzozero, Waterbury
W. Holbrook Lowell, Jr., Hartford

Special Societies:
Connecticut Hospital Association:
William H. Curley, Bridgeport
Connecticut Pharmaceutical Association:
Barnett Greenhouse, New Haven
Connecticut State Dental Association:
Samuel C. Harvey, New Haven

Change In By-Laws Passed by House of Delegates

Revision of Article X, Section 3, Paragraph 2, of the By-Laws of the Society:

Committee on Clinical Congress: The Council recommends to the House of Delegates that paragraph 2 of Section 3, Article X, be deleted in its entirety and that the following be substituted therefor:

Par. 2. The Council shall nominate to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purposes of the committee shall be to plan and make available programs of postgraduate education in medicine, to arrange and conduct the annual Clinical Congress of the Society and to coöperate with university and other agencies for the extension of postgraduate education of physicians.

Dr. Fulton to Lecture in England

Dr. John F. Fulton, chairman of the Yale Depa- ment of Physiology and noted biographer, will - liver the William Withering Memorial Lectures t the University of Birmingham, England, in Ju Dr. Fulton will speak on the physiological basis f the surgical operation known as frontal loboton which has achieved increasing international inter- in recent years. His addresses in England will received with marked interest since the mo enthusiastic advocates of the brain operation Britain believe that, through its use, it may be po sible to cut down the population of mental hospit from one third to one half.

In addition to delivering the Withering Lectur Dr. Fulton will receive an honorary Doctor Science degree from the University of Birmingha on July 3. The degree will be conferred by Antho Eden, chancellor of the University, and he will presented by the Public Orator, Thomas Bodki director of the Barber Museum of Fine Arts.

The William Withering Lectures were esta lished at the University of Birmingham Medic School in honor of one of the university's mo distinguished graduates who discovered the actio of the drug digitalis in 1785. Last year the Withe ing Lecturer was Professor Albert von Szen Gyōrgi, Hungarian medical research worker wh received the 1937 Nobel Prize for Physiology an Medicine for his isolation of Vitamin C.





COURTNEY C. BISHOP, M.D.

Courtney C. Bishop of New Haven has been med to represent the New Haven County Medi- l Association on the State Medical Society's gov- ning Council, and W. Bradford Walker of Corn- all has been elected councilor from the Litchfield ounty Medical Association.

Formerly secretary of the New Haven County edical Association, Dr. Bishop is chairman of the wly created Committee on Postgraduate Educa- n, and chairman of the Committee to Study the rganization and Objectives of the State Medical Society. Dr. Walker is past president of the Litchfield County Medical Association, a member of the Connecticut Public Health Council, and a former president of the Connecticut Public Health Association.



W. BRADFORD WALKER, M.D.

Dr. Klumpp Elected Head of Pharmaceutical Manufacturers

Theodore G. Klumpp, president of Winthrop- earns, Inc., and a member of the Connecticut ate Medical Society, has been elected president the American Pharmaceutical Manufacturers ssociation. Before becoming associated with Win- rop, Dr. Klumpp taught internal medicine at Yale niversity Medical School, was adjunct clinical rofessor of medicine at George Washington Uni- rsity, was chief of the Drug Division of the nited States Food and Drug Administration, and rector of the Division of Drugs, Foods and Physi- l Therapy, and secretary of the Council on harmacy and Chemistry of the American Medical ssociation.

Dr. Truex to Speak at Northwestern University

Dr. Edward H. Truex, Jr., member of the associate staff at Hartford Hospital, and formerly chief of aural rehabilitation at the Deshon General Military Hospital, will be one of the principal participants in a Symposium on School and Clinic Procedures in Audiology to be conducted at the summer session at Northwestern University.

On June 30 Dr. Truex will speak on "The Otological Examination," July 1, "Implications of Otological Findings," and on July 2, "Otological Management of Hearing Loss." The symposium will start on June 25 and will continue through August 27.

CONNECTICUT AT THE NATIONAL HEALTH ASSEMBLY

The National Health Assembly in Washington May 1-4 called by Mr. Oscar Ewing, Federal Security Administrator, was perhaps the broadest conference on health, welfare and allied subjects ever held. What the total attendance was has not yet been reported, but it was certainly close to a thousand. The Executive Committee consisted of forty individuals representing various professions, service organizations, governmental agencies, labor unions, and industrial interests. Medicine was represented on the Executive Committee by Dr. Edward L. Bortz, Dr. Paul R. Hawley and Dr. R. L. Sensenich.

Howard Kline, well known to many Connecticut people, is to be congratulated on the care with which the sessions were arranged and the orderliness with which the entire conference was carried out. It was not possible for any one person to attend even a fraction of the meetings and discussion groups, so reporting of it must be a composite effort and because reports and comments have already been widely published, the JOURNAL will concern itself chiefly with the participation of Connecticut physicians. Unlike a similar assembly held in 1938, medicine was largely represented at the 1948 session and there were physicians from almost every State and representing every interest of medicine. Those attending from Connecticut included James R. Miller, Hartford, who presided ably as the chairman of the Section on Chronic Disease and the Aging Process. This was an important section of the Assembly and next to the Section on Medical Care probably drew the largest attendance. Theodore Klumpp, now of New York, but still a member of the Connecticut State Medical Society, gave the principal address at a general luncheon when chronic disease was the subject for discussion. Benjamin V. White, Hartford, and William R. Willard, New Haven, were participants in the work of the Section on Chronic Disease. Cancer came in for a good deal of consideration.

The Section on Medical Care considered the organization and financing of personal health services, health insurance, prepaid medical and hospital care, and the steps to be taken toward making better health care available to the population. It was the most largely attended section and at times several hundred people were present in the auditorium where it met. Hugh R. Leavell, now of the Harvard School of Public Health, but for quite a time resident of New Haven, presided over this Sectic with equanimity and fairness, although faced ofte with trying debate. John P. Peters, New Have was a participant in this section. This section co cluded that the best means of meeting the bill f this service was prepayment and recommende extension of existing Blue Cross and Blue Shie Plans. In a minority report, however, Nelso Cruickshank of the American Federation of Labo said that his and other labor organizations favore compulsory Federal insurance.

Leona Baumgartener, formerly of New Have now with the Department of Health in New Yo City, presided over the Section on Maternal ar Child Health.

James M. Cunningham, Hartford, was in the Se tion on Mental Health and the State office of t Society was represented by Miss Mooney, who w an invited participant, in the Section on State ar Community Planning for Health. This section w presided over by Florence Sabin of Colorado ar considered the importance and responsibility voluntary community agencies in the health ar welfare pattern.

Creighton Barker was an invited participant the Section on Professional Personnel, representir the Executive Committee of the Federation of Sta Medical Boards of the United States. This sectic concerned itself with the pressing problem of med cal education in both the undergraduate and grad ate fields and it heard illuminating estimates of t country's needs for physicians, nurses and dentis during the next decade. It became obvious, as t discussions progressed, that medical, nursing a dental education in America is quantitatively i adequate and that 1,500 additional physicians shou be graduated each year for the next 10 years order to meet the anticipated requirements. The has been a wide difference of opinion on this subje with many well informed people holding to t idea that the present output of about 5,500 medic graduates a year is adequate, but as the discussic developed during the Assembly, to which perso experienced in many fields added their statistics a opinion, it became clear to the section that o country will be short of medical personnel a fe

ears from now unless something is done about it. n dentistry, although the number needed is not as rge, the demand has already become acute. Everyne knows the circumstances in the nursing profesion and it has been under study by several comittees, foremost of which is the American Medical ssociation Committee on the Nursing Problem nder the chairmanship of Thomas P. Murdock of leriden. The number of nurses that this country ust have by 1960 is staggering. No one seems sure t just how it is to be met. Representatives of the rmy, Navy and the Veterans Administration were constant attendance in this section and were finite about the number of physicians and nurses ese services will require.

Other Connecticut people who were in the ssembly included C. E. A. Winslow, retired direcr of the Yale School of Public Health; James A. amilton, former director of the New Haven Hostal, a member of the Section on Hospital Facilies; and John Hubbard, formerly of New Haven, presenting the American Academy of Pediatrics.

On the basis of abstracts prepared for him by the ction chairmen, News Commentator Quincy owe of the Columbia Broadcasting system dered on Tuesday morning, May 4, a final sumary of the work of the Assembly. Two other ports of the Assembly have been prepared—a port by Federal Security Administrator Ewing to esident Truman and a more or less documentary nthesis of the section reports assembled by the ction chairmen themselves.

Many health needs were pointed out. There was neral agreement as to the shortage of both practal and registered nurses; as to the need for a eater number of medical schools, hospitals, diagstic centers, and public health units; with regard the need for fluid funds for salaries in investigave careers; as well as for earlier diagnosis and more despread use of rehabilitation techniques in ronic disease. Great emphasis, particularly in the re of chronic disease, was placed upon the necesy for community planning for better coordination of existing public health and private welfare vices. Special attention was given to such regional or specialized problems as rural health, dental alth, mental disease and physical medicine. Most the delegates agreed that large amounts of money ould be needed to effect the desired changes, and oked to the Federal government for some help this regard.

The specific recommendations of so large a group are too numerous to be recounted here. More important than the recommendations was the atmosphere of the Assembly. Trained workers with fundamentally divergent political and economic viewpoints gathered with a unity of spirit in seeking a common goal, the improvement of this Nation's health. It was generally felt that the areas of agreement between the various groups were larger than had been anticipated in advance. The most highly controversial of subjects, such as Federal Health Insurance, were discussed in section and subsection meetings and included in their recommendations, but a conscientious effort was made to exclude them from the prepared addresses at the general sessions.

It will take a number of years to appraise the tangible outcome of the Assembly. It certainly brought together a large and interested group of people interested in the health and welfare field and many nationally prominent experts.

Peripateticus

New England Obstetricians and Gynecologists Meet

The spring meeting of the New England Obstetrical and Gynecological Society attracted 175 members to Hartford on May 5. Operative clinics were conducted at St. Francis and Hartford Hospitals from 8 to 10 A. M. Following these a program of papers was presented at St. Francis Hospital. Speakers at this session were Asa C. Watson, resident in obstetrics at Hartford Hospital; Louis P. Hastings, chief of department of pathology and D. G. Bard, resident pathologist, St. Francis Hospital; W. Leslie Smith, assistant gynecologist and obstetrician, Hartford Hospital; Timothy F. Brewer, cardiologist, St. Francis Hospital; Louis F. Middlebrook, associate gynecologist and obstetrician, Hartford Hospital; and a group from Grace-New Haven Community Hospital, Alan Foord, James Kleeman, and Mrs. Gibson Danes.

The New Haven group discussed the so-called rooming-in unit plan for obstetrical patients which features keeping mother and infant in the same room immediately after the birth of the infant. Prime mover in this project which has been in operation since October 1946 is Edith Jackson, associate clinical professor of pediatrics at Yale University

School of Medicine. The experiment is being carried out at New Haven in a single 4-unit room. The special room has a soundproof ceiling. The walls are painted a soft pink and it has flowered cretonne curtains. For the first two or three nights the babies are kept in cubicles at the end of the room to insure proper rest for the mothers; after that they stay next to the mothers' beds.

A sumptuous luncheon was served at St. Francis Hospital, then the members were conducted through the new Hartford Hospital. The afternoon session was held at the Hunt Memorial Building. Three guest speakers presented subjects for discussion: William T. Kennedy of New York City, "The Rectum Before and During Labor, and Its Restoration When Indicated;" William E. Studdiford of New York City, "Bleeding During Pregnancy;" and James F. Norton of Jersey City, "The Toxemias of Pregnancy." Dr. Norton's paper provoked a lively discussion.

The session closed with a dinner at the Hartford Club enlivened by orchestral and vocal music and followed by entertainment produced by several members.

The committee in charge of arrangements for this session comprised Joseph H. Howard, Bridgeport, chairman, Lewis P. James and Louis F. Middlebrook, Hartford.

Bristol Hospital Dedicates New Building

Simple dedicatory services inaugurated the reception at the opening of the Barnes Medical Building of the Bristol Hospital on April 3. The new medical unit is the latest word in hospital construction and is fitted throughout with the most modern equipment. It ranks with the finest hospital buildings of its type in the nation according to members of the building committee. Through popular subscription, the interest of the manufacturers and the generosity of the Barnes family, the new medical wing is now an acutality.

In the building itself the bed rooms are cheerful with colorful decoration and constructed with an eye to efficiency and convenience.

On the third floor there will be a total capacity of 29 beds including private, two-bed rooms and four-bed rooms. Utility rooms and service conveniences are on every floor. Due to removable curtains, the semi-private accommodations can be made almost as private as a single room. The four-bed rooms are divided by a solid half partition a well for the sake of privacy.

Arrangements on the second floor are somewha similar but here one of the best features of th building is located. It is the spacious solarium oc cupying the entire west side of the building.

On the main floor a comfortable waiting roo adjoins the lobby. There will be three clinic room a consultation room and an excellent doctor library.

Some of the features of the building includ rooms already piped for oxygen to obviate th necessity for carting the heavy tanks around; a audible call service whereby the patient may con verse with the nurse from bed without actuall having to summon her by signal; specially con structed refrigeration for flowers, for blanke warmers, and for complete up-to-date hospit facilities of every description. A complete stainle steel equipped kitchen and new laundry will b show places for visitors.

Cancer Handbook for Dentists

The Connecticut Cancer Society has announce publication of a new "Cancer Handbook for Den tists." Comprising fifty-two pages, and illustrate with color and black-and-white photographs, th publication was recently distributed to all dentists i Connecticut.

Agencies which cooperated with the Canc Society in preparation of the handbook were th Connecticut State Medical Society, the Connecticu State Dental Association, and the State Departmen of Health.

Authors of the book, which is expected to attrac national interest, were Wilbur D. Johnston, D.D.S M.D., New Haven; Wilson R. Conran, D.D.S., Har ford; Harold R. Connelly, D.D.S., Bridgeport; an Lewis Fox, D.D.S., of South Norwalk. The autho are members of the Cancer Research Committee o the state dental group.

Members of the editorial board representing th Cancer Society were Dr. A. Nowell Creadick, Ne Haven, former president of the Society, and Har F. Morse, New London, chairman of the Society Campaign Committee.

Intended for professional use by dentists as a aid in the early detection of malignant lesions, th handbook deals with the cancer problem in Co necticut, dental examinations, cancer of the ski

mors of the mouth, and laboratory examinations suspect tissue. The manual points out that from 935 through 1946 11 per cent of the cancer cases corded in Connecticut hospitals occurred in the ead and neck regions. In 1944 a total of 5,379 can- r deaths in the United States were caused by sions of the mouth and throat, according to statis- s of the American Cancer Society.

Greater Hartford Organizes Heart Association

On April 20 the first local Heart Association was ganized in Greater Hartford. Interested physi- ns who had served on the committee for the 48 Heart Week Campaign for Funds met at the unt Memorial and elected officers and approved statement setting forth the objects and purpose of e local association.

The following officers were elected: Robert S. arr, president; William A. Wilson, vice-president; lbert L. Larson, secretary; Howard W. Brayton, imothy F. Brewer, Arthur B. Landry, and Peter Steincrohn, board of directors; Alfred L. Burg- rf, City of Hartford health officer, and Eugene Lamoureux, State of Connecticut Department of ealth, ex officio consultants; Hartford National nk, Mr. Fred R. Coles, treasurer.

Timothy F. Brewer was appointed delegate to end a meeting at Atlantic City on May 2, 1948.

Allergy Society Formed

The Connecticut Allergy Society was organized d held its first meeting in Fairfield on Thursday, ay 19, in conjunction with the Connecticut State edical meeting. A constitution was read and ac- pted and the following slate of officers was ected: President, S. W. Jennes, Waterbury; Vice- esident, Barnett P. Freedman, New Haven; cretary-Treasurer, Russell Webber, Waterbury; xecutive Committee, A. F. Roche, Hartford, Vin- nt P. Cenci, Hartford.

Metropolitan to Launch Child Safety Campaign

A reduction in the number of child accidents, th fatal and non fatal, is the objective of an inten- e child safety campaign to be launched this fall the Metropolitan Life Insurance Company with the cooperation of the U. S. Children's Bureau, the American Academy of Pediatrics, and the National Safety Council. Accidents are the leading cause of death among children of more than 1 year of age, with death rates per 100,000 population far surpassing those of any other cause. For example, in 1946, according to the experience of the Metropolitan among its Industrial policyholders, the accident death rate among children from 1 to 4 was 48.1 per 100,000, as compared with a rate of 28.2 per 100,000 for pneumonia, the next leading cause of death. It is significant that at this age group there has been little improvement in the past 15 years, although the death rate from disease has been cut approximately 67 per cent.

In the age group 5 to 9, the death rate for accidents was 25.7 per 100,000 as compared with a rate of 4.6 for rheumatic fever and organic heart disease, the next cause. In the age group 10 to 14, the death rate for accidents was 20.8, and that for rheumatic fever and organic heart disease, 7.2.

The present relatively low death rates from all non accident causes, as compared with those of but a few years ago, are the result of advances in medical science and concentrated efforts in the field of child health. Efforts must now be intensified to bring about a reduction in the number of child accidents as well. The program is planned to encourage public health, medical, safety, and other organizations, as well as the general public, to give even greater attention to the child safety phase of the child health program.

As part of the campaign the Metropolitan has prepared a 12-page illustrated booklet, "Help Your Child to Safety." While the booklet is addressed to parents and stresses the importance of cooperation on the part of all members of the family regarding child safety, it also emphasizes some significant ways of combatting physical hazards and unsafe practices resulting in child injuries. The Metropolitan Field Force throughout the United States will cooperate in this campaign, as it has in so many others, by distributing the booklet and in other appropriate ways will help to make the public aware of what can be done to cut down the tremendous toll of child accidents.

Supplies of the booklet and copies of statistical charts, prepared talks, suggested press releases, and other source material will be available upon request by September 1 for use in local organized child safety programs.

EVERYBODY REPORTS NEWS

Everybody plays a part in news reporting. Reporting the day's happenings is a usual type of conversation — it is natural, human, and necessary.

The modern American newspaper implements this useful activity — rolling from its presses at thirty thousand copies an hour a city newspaper brings to thousands of people every day organized reports of what has happened and what may happen. It is one of our most effective means of communication.

Newspapers Are Valuable In Public Relations

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PUBLIC AFFAIRS

WHO Becomes a Permanent Agency

With the ratification of its Constitution by Mexico and Byelorussia, the World Health Organization on April 7 passed from its Interim Commission phase into the status of a full fledged Specialized Agency of the United Nations. The action by Mexico and the Byelorussian Soviet Socialist Republic made a total of 27 UN members, one more than the required number, which have ratified the WHO Constitution. Accepted by the delegates of sixty-one nations at the International Health Conference in July 1946, the Constitution stipulated that it would "come into force when twenty-six members of the United Nations have become parties to it" by depositing their ratification documents with the Secretary-General of the United Nations at Lake Success.

First World Health Assembly Assured

The ratifications received on April 7 mean that the first World Health Assembly will take place with delegations present from at least 35 nations, 27 UN members and 8 non members. The WHO becomes the United Nations' ninth Specialized Agency—and the first in which the United States is not a member. France is the other major power which has not as yet ratified the WHO Constitution. In the case of the United States, the bill for ratification had already passed the Senate last year and had been unanimously approved in the House Foreign Relations Committee. However, the House of Representatives Rules Committee—by a vote of five to two—tabled the bill, without explanation.

NEWS FROM WASHINGTON

Selective Service Again

The Armed Services Committees in both Houses of Congress are studying plans for the re-establishment of a Selective Service Program. Public hearings have been held, bills have been introduced and both Houses are considering the matter in executive session.

Excerpts from the two bills, relating to the induction of physicians, follow:

EXCERPT FROM THE SENATE BILL

"Notwithstanding any other provision of this title, the President is authorized, pursuant to requisitions submitted by the armed forces, to make special calls for members of the medical, dental, and veterinary professions, who have not yet reached the age of forty-five at the time of such call, in such classifications and in accordance with such priorities as he shall determine and persons called hereunder shall be liable for induction for service in the armed forces for twenty-four consecutive months in accordance with such procedures as the President shall prescribe."

EXCERPT FROM THE HOUSE BILL

"Notwithstanding any other provision of this Act, the President is authorized, pursuant to requisitions submitted by the armed forces, to make special calls for members of the medical, dental, and veterinary professions, who have not yet reached the age of forty-five at the time of such call, in such professional categories as he shall determine, and persons called hereunder shall be liable for induction for not to exceed twenty-four months of service in the armed forces: Provided, That no member of the medical profession shall be inducted pursuant to this subsection until the ratio of doctors of medicine in active service to the total active strength is

not more than three doctors of medicine per one thousand total active strength: Provided further, That no dentist shall be inducted pursuant to this subsection until the ratio of dentists in active service to the total active strength is not more than two dentists per one thousand total active strength: Provided further, That no veterinarian shall be inducted pursuant to this subsection until the ratio of veterinarians in active service to the total active strength is not more than one veterinarian per two thousand total active strength; Provided further, That when such ratios are attained the number of persons inducted pursuant to this subsection shall be not more than necessary to maintain such ratios in the armed forces: And provided further, That in computing the total active strength of the armed forces for the purposes of this subsection there shall be included the number of those to be enlisted or inducted during the thirty days next following the date of such special calls for members of the medical, dental, or veterinary professions less the number to be discharged or separated during such period.

"In inducting persons pursuant to subsection (n) of this section, the President shall induct, in the following order of priority, first, those who are less than thirty-five years of age and have had less than ninety days' prior active honorable military or naval service; second, those who are over thirty-five years of age and have had less than ninety days' prior active honorable military or naval service; third, those who participated as medical or dental students in the Army specialized training program or similar programs administered by the Navy and have served on active duty more than ninety days but less than twenty-four months (exclusive of time spent as intern); fourth, those whose total active honorable military or naval service is less than twenty-four months; fifth, others as prescribed by the President.

"Sec. 6. The President shall have authority to induct into the armed forces of the United States for service under this Act no greater number of men than the Congress shall hereafter make specific appropriation for from time to time."

Dr. James Sargent and Dr. Harold Diehl, of the Council on National Emergency Medical Service, and Dr. Elmer L. Henderson, chairman of the Board of Trustees of the AMA, were in Washington to confer with the staff of the House Armed Services Committee and the chairman and members of the staff of the Senate Committee on Armed Services. They presented a statement to both committees. By invitation of Senator Gurney, there were present at the Senate Conference the following: Mr. John Noble, special assistant to Secretary Forrestal; Colonel Paul I. Robinson, of the Army, Captain J. P. Logue of the Navy, and Colonel Gordon G. Bull, of the Air Service. These three are also on the Subcommittee of Personnel of the Hawley Committee.

At its recent meeting in Chicago, the Council on National Emergency Medical Service adopted resolutions assailing the government's proposal to induct physicians by law into the armed services.

The Council's objections, summarized in a statement prepared by hte AMA Bureau of Legal Medicine and Legislation, have since been reaffirmed by the Executive Committee of the AMA Board of Trustees. The complete statement, which has been forwarded to congressional committees considering proposed legislation to reactivate Selective Service follows:

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION ON PROPOSALS TO INDUCT PHYSICIANS AS SUCH IN CONNECTION WITH THE CONTEMPLATED REVIVAL OF THE SELECTIVE TRAINING PROGRAM

Preliminary Committee prints of Senate and House bills to provide for the Common Defense by Increasing the Strength of the Armed Forces of the United States, (and to Provide for a Universal Training Program) contain a section which would authorize the President, pursuant to requisition submitted by the armed forces, to make special calls for members of the medical, dental and veterinary professions, which have not yet reached the age of forty-five at the time of such call, in such classifications and in accordance with such priorities as he shall determine. Persons so called will be liable for induction for service in the armed forces in accordance with such procedures stated or as the President shall prescribe.

Such a provision is unnecessary, discriminatory and constitutes a reflection on the patriotism of the medical, dental and veterinary professions. Confining this statement to the proposed induction of physicians, it is strongly urged that during World War II, the medical profession met every demand for medical personnel without compulsion by law. It will do so again if the need arises. The provision is therefore unnecessary and infers that in the case of urgency the medical profession will not respond to the needs of the armed services. It would seem

o be predicated on a lack of faith in the patriotism f members of the profession. There is nothing in he history of American medicine to warrant such n inference.

If a revival of the selective service program is ade effective, there will arise a need for scientific nd technical personnel, other than the three groups pecifically mentioned, who are above the age limits o be applied to selectees generally. Until provision s made for the induction of such other personnel, t is discriminatory to single out physicians, dentists nd veterinarians and subject them to compulsory nduction.

The Association, through its Council on National mergency Medical Service has been actively en- aged for many months in planning for the medical, ealth and sanitary needs of the nation in event of a ational emergency. At a meeting held in Chicago, uesday, April 6, the Council gave careful consid- ration to the present proposal to induct physicians y law into the armed services. Resolutions were dopted embodying in substance the objections to he proposal summarized in this statement. These bjections have since been reaffirmed by the Execu- ve Committee of the Board of Trustees which has uthorized this statement.

It is urged, therefore, that the provision under hich physicians may be inducted as such by com- ulsion of law be eliminated from proposed legisla- on to revive selective service.

The greatest challenge confronting Congress and he medical profession today is "the proper and dequate provision for the care of the great number f horrible civilian casualties that are promised if World War III is to come."

This statement was made by Dr. James C. Sargent f Milwaukee, chairman of the Council on National mergency Service of the AMA, before the Armed ervices Committee of the House of Representatives n expressing opposition to parts of Section 4 of HR bill No. 6274. This bill as now worded would uthorize the President, pursuant to requisitions ubmitted by the armed forces, to draft physicians bove the age of 25 stipulated as basic in the pro- osed law.

"To give to the Military Establishment carte lanc as this bill proposes to do, would surely lead o the same over procurement of medical personnel s before," Dr. Sargent said. "And if another war is o come—biologic and atomic warfare this time—large disaster areas with terrible civilian casualties must be expected and must be adequately provided for if the Nation is to survive.

"Ordinary civilian pursuits, agriculture and especially industry—the very foundations of our national war strength—will never survive the high casualties in store for them in another war if civilian doctors are to be thinned down again to the one to 1,500 ratio that was reached during the last war.

"The special provisions in Section 4 (c) and (d) of HR6274 set the pattern for just such an unsafe distribution of physicians and set the stage for just such a national catastrophe."

The Armed Services Committee of the House of Representatives were told that a survey made by a special committee of the AMA of some 50,000 doctors revealed:

1. There were far more civilian physicians procured for the armed services during World War II than were effectively needed or used.

2. The subtraction of this large group of physicians from the civilian population left a shortage that was dangerously acute and sorely noticed despite the remarkably healthy state of the nation throughout the war years.

"A national tragedy would surely have occurred had we experienced an influenza epidemic like that following World War I or had we suffered civilian war casualties such as the bombed countries of Europe experienced in World War II," Dr. Sargent said.

The Council chairman added that "if the nation is to survive another war there can be no brooking the waste of medical talent that prevailed in the Army, Navy and Air Force throughout the war just passed." Happily, he said, the Military Establishment, from the Secretary of Defense down, is working toward far better use of the medical personnel and facilities of the three services.

The studied belief of the Council on National Emergency Medical Service and the Board of Trustees of the American Medical Association, stated Dr. Sargent, is that a special provision in the law for the drafting of doctors is "both unnecessary and unwise."

"Because of the accelerated program of medical education carried on during the war years, doctors are graduating today well under the age of 26. Through this circumstance, doctors made available

under the general draft provisions of HR6274 would be wholly adequate to meet the numerical requirements of medical officer personnel for the increased strength of the armed forces authorized in the bill."

The point is raised, and properly so, that this would furnish only young, recently graduated physicians. That there is need for some older physicians of special talent is obvious. Such need cannot be great, however, considering the fact that this bill provides for a peace time expansion of the armed forces that does not contemplate heavy casualties of war and, important to note, provides for the medical care of young men in the prime of life and hand picked for their physical fitness.

"There are other ways, less onerous than this proposed legislation, to provide the expert services of experienced physicians and surgeons needed for the expanding Army, Navy and Air Force. The Veterans Administration has pioneered in the use of highly skilled specialists in civilian practice as part time consultants and the unprecedented excellence of the care that is being given veterans today under such a system merits the serious notice of the Military Establishment.

"Today each city of size in America holds able and thoroughly experienced specialists of every category who are not too deeply rooted to consider rejoining the military as a career were such service made somewhat more attractive. But they recall the barrier that age placed against obtaining rank and pay that was commensurate with their exceptional talents. And they recall the withering experience of long periods of inactivity and of non medical duties."

Doctors, both in and out of service must have clinical medical work to challenge their abilities and keep them professionally alive. While there are certain real inducements to attract able medical talent to a career in military medicine they simply are not enough. Purely administrative changes, dealing with rank and duty assignment, could and would over night minimize the medical personnel problems that so concern the armed services today.

"And in the end, if neither of those means are to be employed and experience proves that soldiers and sailors are in need of medical care the profession of America will see they get it, draft or no draft. They did it handsomely in the last war, as, indeed, they always had before. And they would do it again."

Favors Public Health Bills in Principle

In a statement presented to the House Committ on Interstate and Foreign Commerce recently, D James R. Miller, of Hartford, a member of the AM Board of Trustees, approved in principle the iden cal bills introduced by Representatives Dolliver ar Priest, which would assist the states in the develo ment and maintenance of local public health uni

In his statement, Dr. Miller said that for mar years the AMA had been active in promoting th establishment and maintenance of public heal activities, on federal, state and local levels.

The AMA, he said, has even recorded its a proval of federal aid to assist in the development local health units, but added: "The principle federal aid through provision of funds or personn is recognized with the understanding that local are shall control their own agencies as has been estal lished in the field of education. Health departmen should not assume the care of the sick as a functio since administration of medical care under suc auspices tends to a deterioration in the quality the services rendered."

Dr. Miller suggested several amendments whic he believed would help to make the legislation mo effective. The bills define a local public health un as a governmental authority of a local area autho ized to provide in such area "basic public heal services," but, he said, there is no definition as what shall constitute "basic public health services

"It is our viewpoint," the statement said, "th the law itself should state what shall constitute 'bas public health services' and, as a corollary, that suc determination should not be left to any feder administrative officer."

"Doctor's Orders" on Vacation

"Doctor's Orders," the weekly radio progra which the State Medical Society has sponsored sinc October 1947, went off the air for the summ months with the broadcast of Sunday, May During the summer it is planned to review pa programs with a view to initiating a new seri next fall. One hundred and sixteen members of th Society participated in the series during its weeks of operation. The programs were broadca every Sunday afternoon over the Yankee Networ WONS in Hartford, WICC in Bridgeport, WWC in Waterbury, and WNLC in New London.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

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Veterans Studying Medicine

One in every 25 World War II veterans training nder the G. I. bill is preparing for a career in iedicine or in a related field, a Veterans Administ-ation survey revealed.

On December 1, 1947—date of the survey—101,447 x-servicemen and women were enrolled in educa-onal institutions and were training on the job for iedical positions and professions ranging from boratory technicians to surgeons.

More than 40 per cent, or 43,558 were studying iedicine. Of these, 18,265 were in pre-medical aining, and 25,293 were enrolled in medical chools.

A total of 17,486 were in dentistry. Of these, 244 were taking pre-dental training; 7,314 were dental schools; 2,600 were studying dental iechanics; and 328 were training to be dental ygienists.

Veterans training to become pharmacists num-ered 13,245. All but 890 were in schools of pharm-cy. The 890 were training on the job in pharmacies.

A total of 5,194 were training to become labora-ory technicians and assistants. About two-thirds, r 3,628, were training on the job, and the remaining ,566 were enrolled in school courses.

Of the remaining veteran-trainees, 6,835 were udying optometry; 4,459, nursing; 3,463, chiro-ractic; 1,789, veterinary medicine; 1,166, pre-eterinary medicine; 1,145, chiropody; 712 osteo-athy; 357, physical therapy; 591, public health iedicine; and 1,066, other types of medical services.

The VA survey lists occupational fields of some ,000,000 veterans studying in schools and colleges, nd 546,000 training on the job.

Veterans are eligible for education and training nder the Servicemen's Readjustment Act (G. I. ill) if they served in the armed forces between eptember 16, 1940 and July 25, 1947; had 90 days r more of active service; and were released under conditions other than dishonorable.

The 90 day minimum service requirement is waived in the case of veterans released because of service connected disabilities.

Progress in Use of Radio-Isotopes

"Encouraging" progress, especially in the development of new methods of diagnosis, is revealed in first reports from doctors working with the Veterans Administration's radio-isotope research program.

Dr. George M. Lyon, chief of VA's Radio-isotope Section, also revealed that leukemia patients are now being treated with radio-phosphorus in most of the seven VA hospitals having radio-isotope units and that another atomic pile byproduct, radio-iodine, is being employed to treat some thyroid diseases.

"It may be too much to expect this new form of treatment to prolong life or cure the leukemia patient," Dr. Lyon said, "but it certainly does reduce the suffering and makes their days more bearable."

Reports received to date on the use of radio-phosphorus in treating leukemia, a form of blood cancer, indicate that unpleasant reactions frequently produced in these patients by x-ray treatment do not occur, that symptoms resulting from the disease are more readily controlled and that the patient usually has a much shorter stay in the hospital.

Dr. Lyon, former safety consultant for the Manhattan Engineer District on atomic bomb production, added that the leukemia research has not yet progressed to the stage where it can be said that all persons with this disease should receive radio-phosphorus.

Although VA doctors, and those assisting the agency in its research program, have been using radio-iodine for several months to aid in the diagnosis of thyroid diseases. Dr. Lyon said there is not yet sufficient information available to determine how successful it will prove for treatment.

VA radio-isotope units also are making studies on metabolic diseases, on circulation of the blood, and on the patency of blood vessels of the peripheral circulation.

It is expected that isotopes will continue to prove most valuable in the study of various internal diseases and that their use for treatment will be limited. Several of the nation's leading medical schools and research groups are conducting similar radio-isotope projects.

In this new research technique a radioactive substance is administered. Distribution of the radioelements in the body is then checked either by means of sensitive photographic films or with electrical impulse equipment, including the Geiger counter, the device used by engineers in atomic energy plants.

Three widely known radio-isotope scientists serve on VA's Central Advisory Committee. They are: Dr. Shields Warren, of the Harvard University School of Medicine and Atomic Energy Commission; Dr. Stafford Warren, dean of the School of Medicine, University of California at Los Angeles, and former medical director of the Manhattan Engineer District; and Dr. Hymer L. Friedel, professor of radiology at Western Reserve University, Cleveland. Two well known medical professors, Dr. Hugh Morgan, professor of medicine, Vanderbilt University, and Dr. Perrin H. Long, professor of preventive medicine, Johns Hopkins University, complete the advisory group.

Radio-isotope units are located in VA hospitals at Los Angeles and Van Nuys, California; Framingham, Mass.; New York City, Cleveland; Chicago; Minneapolis and Dallas. Five additional VA hospitals are scheduled to receive units within the next two years.

Speech Restorative Training

Approximately 100,000 World War II veterans who suffered speech impairments in service may be eligible for special restorative training established by Veterans Administration to help them overcome their handicap.

This training is available under the Vocational Rehabilitation Act (Public Law 16) for disabled veterans, when:

(1) The speech impairment interferes with the satisfactory employment of the veteran or the successful completion of his vocational training.

(2) The physical and mental condition of the veteran is such that speech correction training ma be pursued satisfactorily.

(3) There is good promise that specialized trai ing will overcome or reduce significantly the vete an's handicap.

In some cases there may be the possibility th speech impairments can be improved by medic or surgical treatment, VA said. These services w be offered eligible veterans before they are enter in the special speech correction programs.

The type and amount of special training will va with the needs of each eligible veteran.

Generally the training will be offered in spee clinics of colleges, universities, medical cente hospitals and public schools; speech clinics operat as adjuncts to guidance or mental hygiene clinic private speech correction clinics and in curati workshops.

The training centers selected by VA must b qualified and equipped to furnish the specializ training needed by the veteran.

The center must have on its staff competer speech pathologists and correctionists who me the standards set by the American Speech Assoei tion. The physical facilities, equipment and materia of the center must be adequate to furnish effecti training. Medical services for necessary diagnost purposes must be available.

Dr. Wolford Succeeds Dr. Magnuson

Dr. Roy A. Wolford of Washington, D. C., h been appointed assistant medical director for Profe sional Service in the Veterans Administratic Department of Medicine and Surgery. The a nouncement was made by Dr. Paul B. Magnuso chief medical director, with the statement that D Wolford is one of the outstanding men who ha been with VA for many years.

A member of the VA medical staff since 192 Dr. Wolford succeeds Dr. Magnuson as chief Professional Service. Dr. Wolford became acti assistant medical director for Professional Servi on January 16, 1948 when Dr. Magnuson w appointed chief medical director.

VA's Professional Service supervises and c ordinates specific activities of the General Medic Division, the General Surgery Division, the Neur psychiatric Division, the Tuberculosis Division, a the Professional Inquiries unit.

MILITARY BIOGRAPHIES (*Continued*)

These brief sketches of military experience of members of the Society have been compiled from data taken from questionnaires completed by each medical officer. Biographical material for some officers is lacking because questionnaires were not returned.

HAMLIN, CHARLES H., Glastonbury; b. 1916; Harvard 1941; P.H.S. (USCG)—December 13, 1942 Lt. (j.g.), Lt. August 9, 1944; Service Terminated November 15, 1944; Duty—Coast Guard Training Base, Manhattan Beach, N. Y.; USCG Cutter Mohawk; Coast Guard Receiving Station, Boston, Mass.

HAMPTON, LOUIS J., New Haven.

HANLEY J. BAINBRIDGE, Bristol; b. 1913; Jefferson 1939; Army Air—August 1, 1942 Lt., Captain November 15, 1943; Service Terminated December 15; Duty—Presque Isle, Me.; School of Tropical Medicine; Washington, D. C.; School of Aviation Medicine, Randolph Fld., Tex.; Nashville, Tenn.; European Theatre of Operations—England-Ireland-Scotland-France; Awards—2 Bronze Service stars.

HANLEY, JAMES L., JR., Bridgeport; b. 1910; Yale 1935; Army—April 1, 1941 Lt., Captain December 1941, Major August 1944; Service Terminated December 23, 1945; Duty—Stark General Hospital, Chareston, S. C.; Camp Croft; 53rd General Hospital—117th General Hospital (European-African-Middle Eastern Theatres of Operations).

HANSELL, ROBERT J., Greenwich (Entered service from Columbus, Ohio); b. 1905; Ohio 1932; Army—May 17, 1933 Lt., Captain June 6, 1936; Service Terminated November 27, 1944; Duty—Pre-war service in Continental United States; Camp Gordon, Ga.; Camp Bowie, Tex.; Camp North Hood, Tex.; Camp Livingston, La.; Pittsburgh, Calif.; Troop Ship President Johnson; Milne Bay, N. G. (Asiatic-Pacific Theatre of Operations).

HANSEN, PAUL S., Essex (Removed to California).

HARDENBERGH, DANIEL B., Bridgeport; b. 1909; Harvard 1934; Army—July 18, 1942 Captain; Service Terminated October 27, 1945; Duty—39th General Hospital, Auckland, N. Z.—Saipan, M. I. (Asiatic-Pacific Theatre of Operations).

HARPER, PAUL A., Fairfield; b. 1904; Yale 1931; Army—April 30, 1942 Major, Lt. Colonel December 6, 1943; Service Terminated December 29, 1945 (Colonel); Duty—School of Tropical Medicine; 39th General Hospital, Auckland, N. Z.; Hq. Service of Supply, South Pacific; Okinawa; Manila; Awards—Bronze star w/Oak Leaf Cluster; Asiatic-Paicfic Ribbon w/4 battle stars; (Removed to Maryland).

HARRIS, BENEDICT R., New Haven; b. 1899; Yale 1922; Navy—May 14, 1943 Lt. Comdr., Commander November 1, 1945; Service Terminated March 8, 1946; Duty—Brooklyn, N. Y.; USS Haven; Chelsea, Mass.

HARRIS, LOUIS D., Hartford; b. 1908; Tufts 1934; Army Air—December 24, 1942 Lt., Captain December 1944; Service Terminated June 1946; Duty—Fourth Air Force, Ninth Service Command, Continental United States.

HARTMAN, FREDERICK B., New London; b. 1908; Harvard 1934; Navy—November 9, 1942 Lt., Lt. Comdr. July 1945; Service Terminated January 1, 1946; Duty—163rd C.B. Bn., Bainbridge, Md.; Athens, Ga.; USS Hornet (Pacific); Davisville, R. I.; Awards—Asiatic-Pacific Theatre Ribbon w/9 battle stars; Philippine Liberation Ribbon w/2 battle stars; Letter of Commendation, Presidential Unit Citation.

HARTY, JOHN E., Waterbury; b. 1909; Georgetown 1937; Navy—May 20, 1943 Lt. (j.g.), Lt. August 1944; Service Terminated July 17, 1945; Duty—Bethesda, Md.; USN C.B. Training Center, Camp Peary, Va.; Parris Island, S. C.; New England Recruiting Stations.

HARVEY, EDWARD R., JR., Seymour; b. 1915; Yale 1941; Army—July 13, 1942 Lt., Captain April 15, 1943; Service Terminated December 13, 1945; Duty—Continental United States; European Theatre of Operations; Award—Bronze star.

HATHAWAY, JOHN S., New Haven; b. 1903; Harvard 1928; Army Air—August 21, 1942 Captain; Service Terminated June 22, 1946; Duty—School of Aviation Medicine, Randolph Fld., Tex.; School of Aviation Psychiatry, Ft. Logan, Colo.; Stuttgart, Ark.; 314th Bomb. Wing—89th ASG, 29th BG, 19BG (Asiatic-Pacific Theatre of Operations).

HAVILL, RUPERT A., New Haven; b. 1914; Rochester 1939; Navy—August 30, 1943 Lt. (j.g.), Lt. December 1, 1944; Service Terminated July 31, 1946; Duty—Boston, Mass.; Lido Beach, N. Y.; USS Repose, Navy Yd., N. Y.; Asiatic-Pacific Theatre of Operations; (Removed to Auburn, N. Y.).

HAYMAN, MAX (Removed to California).

HAZEN, DONALD R., Hartford; b. 1907; Harvard 1933; Navy—August 22, 1943 Lt., Lt. Comdr. October 1945; Service Terminated June 17, 1946; Duty—Parris Island, S. C.; Birmingham, Ala.; Ft. Pierce, Fla.; Norfolk, Va.; New Orleans, La.; Little Creek, Va.

HEBARD, GEORGE W., New Canaan; b. 1909; Cornell 1936; Army—July 15, 1942 Captain, Major July 22, 1943, Lt. Colonel December 15, 1944; Service Terminated November 5, 1945; Duty—School of Tropical Medicine, Washington, D. C.; 2nd Army Maneuver Area, Tennessee; 35th Evacuation Hospital, 3rd Army (European Theatre of Operations).

HENDERSON, JEAN, Stamford; b. 1905; Columbia 1931; Army—October 8, 1943 Captain; Service Terminated March 8, 1946; Duty Ft. Des Moines, Ia.; Atlanta, Ga.; Ft. Knox, Ky.; Camp Atterbury, Ind.; Camp Barkley, Tex.; Camp Joseph T. Robinson, Ark.; Ft. Sill, Okla.; 376th Station Hospital, Okinawa and Japan (Asiatic-Pacific Theatre of Operations).

HENKLE, ROBERT T., New London; b. 1906; Cornell 1931; P.H.S. (U.S.C.G.)—July 1944 Surgeon (R), Lt. Comdr.;

Service Terminated May 29, 1946; Duty —Marine Hosp., Baltimore, Md.; USS General William M. Black—Transport Duty; Marine Hospital, Norfolk, Va.

HENNESSY, JAMES J., Hartford; b. 1901; Columbia 1926; Navy—April 10, 1942 Lt. Comdr.; Service Terminated April 10, 1943; Duty—Naval Hospital, Philadelphia, Pa.; Navy Recruiting Center, Philadelphia, Pa.

HEPBURN, ROBERT H., Hartford; b. 1913; Harvard 1939; Navy—January 17, 1944 Lt. (j.g.); Lt. June 1945; Service Terminated July 13, 1946; Duty—Newport, R. I.; 3050 C.B. Det., Eastport, Me.; Sub. Base, New London, Conn.; USS Repose (Asiatic-Pacific Theatre of Operations).

HERRMAN, ALBERT E., Waterbury; b. 1896; Harvard 1923; Army—February 15, 1941 Major, Lt. Colonel February 1, 1942; Colonel February 14, 1946; Service Terminated April 1, 1946; Duty—Ft. Devens, Mass.; 29th Field Hospital—Aleutians (Asiatic-Pacific Theatre of Operations) — Scotland - England - Wales, France, Belgium, Germany (European Theatre of Operations).

HERSEY, THOMAS F., New Haven; b. 1906; Tufts 1937; Army—February 20, 1941 Lt., Captain September 11, 1941; Service Terminated February 17, 1946; Duty—Carlisle Barracks, Pa.; England; Oran, North Africa; Italy; France; Awards—3 campaign stars.

HERTZBERG, REINHOLD F., Stamford; b. 1903; Harvard 1926; Navy—July 8, 1942 Lt. Comdr., Commander July 10, 1945; Service Terminated February 25, 1946; Duty—Quonset Point, R. I.; Boston, Mass.; Newport, R. I.; Base Hospital #19, Tinian, M. I.; (Asiatic-Pacific Theatre of Operations).

HERVEY, ZOLTAN P., East Hartford (Entered service from Boston, Mass.); b. 1913; Vienna (Austria) 1938; Army—May 20, 1944 Lt., Captain July 13, 1945; Service Terminated July 18, 1946; Duty —Carlisle Barracks, Pa.; Vancouver, Wash.; San Francisco, Calf.; 189th—232nd General Hospitals, 43d Amphibian Truck Bn., Iwo Jima (Asiatic-Pacific Theatre of Operations); Awards—Distinguished Unit Plaque; 1 combat star.

HESS, ORVAN W., New Haven.

HEUBLEIN, GILBERT W., Hartford; b. 1909; Yale 1934; Army—September 15, 1942 Captain, Major 1944; Lt. Colonel 1946; Service Terminated June 25, 1946; Duty—Percy Jones General Hospital, Battle Creek, Mich.; Awards—Presidential Unit Citation; Army Commendation Ribbon.

HIGGINS, HAROLD G., Milford.

HISCOCK, IRA V., New Haven; b. 1892; Yale 1921; Army (Sanitary Corps)—September 23, 1942 Lt. Colonel, Colonel April 10, 1943; Service Terminated June 22, 1945; Duty—School of Military Government, Charlottesville, Va.; Office of the Provost Marshal General, Washington, D. C.; Office of the Chief of Staff, Civil Affairs Div., Washington, D. C.; Africa-Sicily-England (North African and European Theatres of Operation); Award—Legion of Merit; (Associate Member).

HOFF, EBBE C., New Haven; b. 1906; Oxford (England); 1941; Navy—November 1, 1943 Lt. Comdr., Commander December 2, 1945; Service Terminated November 2, 1946; Duty—Flight Surgeons Course, Pensacola, Fla.; Research Div., Bureau of Medicine and Surgery, Washington, D. C.; Asst. Naval Attache, Medical Research, London, England (European Theatre of Operations); Award—Letter of Commendation; (Removed to Virginia).

HOLLINSHEAD, JOSEPH B., West Hartford; b. 1910; Yale 1937; P.H.S. (USCG)—December 26, 1942 Lt. (j.g.), Lt., Lt. Comdr.; Service Terminated December 1945; Duty—Convoy duty—North Atlantic—Caribbean, Mediterranean.

HOPPER, EDWARD B., Stamford (still in service).

HORN, BENJAMIN, Bridgeport; b. 1905; New York 1929; Army—October 14, 1942 Captain, Major April 21, 1944; Service Terminated February 18, 1946; Duty—Camp Myles Standish, Mass.; Camp Kilmer, N. J.; Award—Letter of Commendation.

HOROWITZ, ISAAC, Bridgeport; b. 1912; Vienna (Austria) 1937; Army—October 20, 1943 Lt., Captain August 1, 1944; Service Terminated November 25, 1945; Duty—107th Evacuation Hospital —Camp Gordon, Fla., Tennessee Maneuvers, Tennessee, Ireland, England, France; 44th Evacuation Hospital; 4th Aux. Surgical Group, France, Luxembourg, Germany; 83rd General Hospital, Austria; Awards—Unit Citation; 5 c paign stars.

HOUGH, PERRY T., Hartford; b. 19 McGill 1932; Army—June 22, 1 Major, Lt. Colonel January 6, 1943, C nel January 7, 1946; Service Termina March 16, 1946; Duty—Atlanta, Ga.; Lewis, Wash.; 29th Medical Laborat Calcutta, C.B.I.

HOVENANIAN, MICHAEL S., N Haven (Entered service from Cambri Mass.); b. 1914; Boston University 19 Army—July 1, 1941 Lt., Captain Ma 19, 1943, Major December 1945; Ser Terminated January 9, 1946; Dut Carlisle Barracks, Pa.; Asiatic-Pa Theatre of Operations; Awards—4 ba stars.

HOWARD, WEAVER O., New Ha b. 1906; New York 1932; Army— tember 21, 1941 Lt., Captain Septem 28, 1942; Service Terminated May 19 Duty—School of Malaria Control; E pean Theatre of Operations; Asia Pacific Theatre of Operations; (moved to Alabama).

HUBERT, GILBERT R., Torrington 1907; Yale 1935; Navy—October 1943 Lt., Lt. Comdr. December 19 Service Terminated January 25, 19 Duty—Sub. Base, New London, Co Mediterranean Theatre of Operati Port Lyautey, French Morocco; Chel Mass.

HUDON, FREDERICK A., Bristol; 1907; Pennsylvania 1937; Army—O ber 10, 1942 Lt., Captain April 24, 19 Service Terminated March 16, 19 Duty—Carlisle Barracks, Pa.; Ca Davis, N. C.; Orlando, Fla.; Camp St art, Ga.; Camp Bowie, Tex.; Europ Theatre of Operations; Camp Benn Ga.; Awards—2 battle stars.

HUMPAGE, NORBERT W., Torri ton; b. 1911; Tufts 1936; Army Ai December 10, 1942 Captain; Ser Terminated July 3, 1946; Duty—Mi Beach, Fla.; San Antonio, Tex.; Marcos, Tex.; Enid, Okla.; Eglin Fi Fla.

HURLBURT, EDWARD G., Bridgep

HURWITZ, ALFRED, Newington (tered service from West Roxb Mass.); b. 1909; Johns Hopkins 19 Army—October 31, 1942 Captain, Ma October 1943, Lt. Colonel Decem 1945; Service Terminated January

95; Duty—First Army, 13th Auxiliary ...gical Group, Mobile Unit, European ...atre of Operations; Awards—Bronze ... 5 battle stars; Presidential Citation; ...x de Guerre w/Palm.

...RWITZ, GEORGE H., Hartford; b. 9...; Maryland 1933; Army—Novem...e 3, 1942 Lt., Captain June 6, 1944; ...ice Terminated January 30, 1946; ...y—Aberdeen, Md.; 120th General ...pital, Manila, P. I.; Tachikawa, ...n.

...SS, JOHN H., Meriden; b. 1916; ...nell 1942; Navy—January 31, 1944 ...(j.g.), Lt. June 1, 1945; Service Ter...ated June 29, 1946; Duty—School ...Chemical Warfare; Norfolk, Va.; ...tington, W. Va.; Shoemaker, Calif.; ...nawa; USS Blue Ridge (North ...a) Asiatic-Pacific Theatre of Oper...ns.

...MOVICH, LEO, Stamford; b. 1904; ...erson 1929; Army—October 6, 1942 ...tain, Major 1944; Service Termi...d May 1946; Duty—Camp Butner, ...C.; Stark General Hospital, Charles...o S. C.; Ft. Moultrie, S. C.

...NOTTI, JOHN P., Plainville; b. ...); Naples, Italy) 1938; P.H.S. ...CG)—July 11, 1944 Senior Asst. ...geon, Surgeon December 3, 1945; ...ice Terminated August 6, 1946; ...y—Marine Hosp., Detroit, Mich.; ... Newport (Atlantic and Pacific); ...G Separation Center #9, Detroit, ...n.

...ING, JAMES G., Hartford; b. 1907; ...onto 1932; Army Air—September ... 1942 Captain, Major; Service Ter...ated December 5, 1945; Duty—Neu...rgical Course, Columbia Univ., N. ... Caribbean Wing; Percy Jones Gen... Hosp., Battle Creek, Mich.; Hallo... General Hospital, N. Y.; England, ...nce, Belgium, Germany (European ...atre of Operations).

...VIN, HAROLD H., New London; b. ...7; Tufts 1934; Navy—March 20, ...4 Lt.; Service Terminated February ...946; Duty—Sub. Base, New London, ...n.; Naval Medical School, Bethesda, ...; Parris Island, S. C.; Camp Lejeune, ... C.; Guadalcanal; Guam; Iwo Jima ...iatic-Pacific Theatre of Operations).

...NMAN,ROBERT, Westport (Entered ...ice from Ashland, Mass.); b. 1904; ...ts 1930; P.H.S.—June 16, 1944 Sen... Asst. Surgeon (R); Service Termi...nated August 17, 1946; Duty—Marine Hospital, Boston, Mass.

JAFFE, SAMUEL A., New Haven; b. 1913; New York 1938; P.H.S. (USCG) —October 1, 1943 P.A. Surgeon, Lt. Commander July 1945; Service Terminated May 10, 1946; Duty—Staten Island, N. Y., USS Sandusky (Atlantic and South Pacific); Alameda, California; Manhattan Beach, N. Y.

JAIVEN, SAUL J., Stamford; b. 1914; New York University 1940; Army—March 10, 1944 Lt., Captain February 1, 1945; Service Terminated September 8, 1946; Duty—Carlisle Barracks, Pa.; Billings General Hospital; Camp Campbell, Ky.; Camp Ellis, Ill.; 121st General Hospital (European Theatre of Operations).

JAMES, LEWIS P., Hartford; b. 1903; Yale 1927; Navy—November 1943 Lt. Comdr., Commander November 1945; Service Terminated March 1, 1946; Duty—Sub. Base, New London, Conn.; USS Mendocino (Asiatic-Pacific Theatre of Operations); Awards—Admiral's Commendation—19th Transport Squadron, Amphibious Forces, Pacific Fleet.

JANUARY, DERICK A., Hartford; b. 1902; Yale 1934; P.H.S. (USCG)—November 16, 1942 Lt., Lt. Comdr. August 1943; Service Terminated December 15, 1945; Duty—Manhattan Beach, N. Y.

JENNES, MILTON L., Waterbury; b. 1912; Tufts 1938; Army—November 1, 1941 Lt., Captain July 18, 1943; Service Terminated March 28, 1946; Duty—Camp Edwards, Mass.; 153rd Station Hospital, Port Moresby, N. G., Southport, Australia; 362nd Station Hospital, Oro Bay, N. G.; 248th General Hospital, Manila, P. I.; Awards—Presidential Unit Citation; Unit Meritorious Servcie Wreath.

JENNES, SIDNEY W., Waterbury.

JENOVESE, JOSEPH F., Hartford; b. 1907; Pennsylvania 1930; Navy—July 10, 1943 Lt., Lt. Comdr., October 3, 1945; Service Terminated April 15, 1946; Duty—Portsmouth, Va.; Cherry Point, N. C.; Bethesda, Md.; San Diego, Calif.

JORDAN, ROBERT H., New Haven; b. 1908; Medical College of Virginia 1933; Army—July 15, 1942, Captain, Major October 21, 1944; Service Terminated February 21, 1946; Duty—Camp Edwards, Mass.; 112th Station Hospital—redesignated 263rd General Hospital; 98th Station Hospital (China-Burma-India Theatre of Operations); Woodrow Wilson General Hospital, Staunton, Va.

JOSEPHS, WILLIAM W., New Haven; b. 1906; Georgetown 1930; Army—September 1, 1941 Captain, Major June 1942; Service Terminated October 1945; Duty—Ft. Devens, Mass.; 16th General Hospital, England; 12th Evacuation Hospital — 104th Evacuation Hospital, France, Luxembourgh, Germany; Awards —4 campaign stars; Unit Citation; Meritorious Award.

JOSLIN, STUART L., Fairfield; b. 1916; Yale 1943; Navy—July 10, 1945 Lt. (j.g.); Service Terminated September 4, 1946; Duty—Naval Hospital, Jacksonville, Fla.; USS Merak.

JOYCE, WILLIAM M., Middletown.

KARPEL, SAUL, New London (Entered service from New York City); b. 1910; Maryland 1936; Army—January 28, 1941 Lt., Captain September 1942, Major January 1946; Service Terminated June 22, 1946; Duty—Camp Livingston, La.; La Garde General Hospital, New Orleans, La.; Station Hospital, POE, New Orleans, La.

KATZ, IRVING, Meriden.

KATZ, MORRIS E., Norwich; b. 1914; Oklahoma 1941; Army—July 1, 1942 Lt., Captian August 1943; Service Terminated January 7, 1946 (Major); Duty—Carlisle Barracks, Pa.; Camp Atterbury, Ind.; Camp Pickett, Va.; England, Normandy, Northern France, Rhineland, Ardennes, Central Europe; School of Psychiatry, Staffordshire, England; Awards—European-African-Middle Eastern Service Medal w/5 battle stars; Bronze Star Medal; Purple Heart; Combat Medical Badge; Presidential Unit Citation.

KATZIN, BENJAMIN, Torrington.

KEATING, GEORGE A., Milford (Removed to Brooklyn, New York).

KEATING, JOHN J., New Milford; b. 1909; New York University 1934; Navy —December 7, 1942 Lt., Lt. Comdr. December 3, 1945; Service Terminated November 24, 1946; Duty—Navy Yard, N. Y.; School of Industrial Hygiene, Columbia Univ., N. Y.; USN Drydock, South Boston, Mass.; Ammunition Depot, Iona Island, N. Y.

KEEFE, WALTER J., Hartford; b. 1904; Maryland 1931; Navy—January 24, 1944 Lt. Comdr., Commander November 5, 1945; Service Terminated January 31, 1946; Duty—St. Albans, N. Y.; Montauk, L. I., N. Y.; Sub Base, New London, Conn.; USS Consolation.

KEENEY, ROBERT R., JR., Manchester; b. 1907; Tufts 1934; Army Air—September 24, 1943 Lt., Captain August 8, 1945; Service Terminated February 23, 1946; Duty—Carlisle Barracks, Pa.; Robins Fld., Ga.; Columbus, Ohio.

KELLY, J. COLMAN, Greenwich; b. 1900; Queens 1928; Army—September 10, 1943 Captain, Major June 11, 1946; Service Terminated September 10, 1946; Duty—Carlisle Barracks, Pa.; Camp Gruber, Okla.; Med. Bn., 79th Infantry Division, England and France; 110th Station Hospital, 279th Station Hospital; 96th General Hospital, England (European Theatre of Operations); Awards—Bronze star; Purple Heart.

KELLY, LEMOYNE C., Waterbury (Entered service from New York City); Navy—March 24, 1942 Lt. Comdr., Commander; Service Terminated December 1, 1945; Duty—Portsmouth, Va.; New River, N. C.; Camp Elliott, San Diego, Calif.; 3rd Marine Division; Southwest Pacific; Lexington, Kentucky; Corvallis, Oregon; Awards—Citation for special work in Arthritis.

KELSEY, WESTON M., Westport; b. 1910; Johns Hospkins 1936; Army Air—September 18, 1942 Lt., Captain September 28, 1943; Service Terminated January 24, 1946; Duty—School of Aviation Medicine; Flight Surgeon—Asiatic-Pacific Theatre of Opreations; Awards—Asiatic-Pacific Theatre Ribbon w/7 battle stars; Philippines Liberations Ribbon w/1 Bronze star; (Removed to Winston-Salem, N. C.).

KENNEDY, ROBERT E., New Haven (Entered service from Ft. Steilacoom, Wash.); b. 1911; Yale 1936; Army—May 2, 1942 Lt., Captain September 21, 1943; Service Terminated January 18, 1946; Duty—Lovell General Hospital, Ft. Devens, Mass.; 36th Station Hospital—96th General Hospital—203rd General Hospital (European Theatre of Operations); Awards—1 battle star; (Removed to Pinebluff, N. C.).

KENNEDY, W. CLEMENT, New Haven.

KETTLE, RONALD H., Norwich; b. 1902; Queens 1928; Army Air—October 17, 1942 Major, Lt. Colonel September 1945; Service Terminated May 23, 1946; Duty—Boca Raton, Fla.; Atlantic City, N. J.; Ft. Dix, N. J.; School of Aviation Medicine, Randolph Fld., Tex.; Buckley Fld., Colo.; Flight Surgeon, 20th Air Force, Guam; Awards—Bronze star; Commendation Ribbon; Asiatic-Pacific Theatre Ribbon w/3 battle stars.

KEYS, ROBERT C., Stamford-South Norwalk; b. 1897; Kansas 1927; Army—July 20, 1942 Captain; Service Terminated April 1, 1946 (Major); Duty—Ft. Banks, Mass.; Waltham Regional Hospital, Mass.; Camp Edwards, Mass.

KINDER, FREDERICK S., Bridgeport.

KIRBY, SAM B., New Haven; b. 1903; Yale 1928; Army—September 1, 1943 Captain, Major November 8, 1944; Lt. Colonel April 22, 1946; Service Terminated May 4, 1946; Duty—Carlisle Barracks, Pa.; Ft. Sill, Okla.; Ft. Bliss, Tex.; Finschaffen, N. G.; Manila, Luzon, P. I.; Camp Edwards, Mass.; Awards—Asiatic-Pacific Theatre Ribbon w/2 battle stars; Philippine Liberation Ribbon w/1 battle star.

KIRSCH, NEVILLE, Hartford.

KLATSKIN, GERALD, New Haven; b. 1910; Cornell 1933; Army—July 1, 1942 Captain, Major February 2, 1943, Lt. Colonel March 4, 1946; Service Terminated April 24, 1946; Duty—School of Tropical Medicine, Washington, D. C.; 112th Station Hospital, Calcutta, India; 30th Station Hospital, Panagarh, India; (China-Burma-India Theatre of Operations); Schick General Hospital, Clinton, Iowa.

KLEBANOFF, HARRY E., New Haven; b. 1900; Yale 1925; Army—July 16, 1943 Captain, Major March 14, 1946; Service Terminated November 11, 1945; Duty—Carlisle Barracks, Pa.; Hoff General Hospital, Santa Barbara, Calif.; Birmingham General Hospital, Van Nuys, Calif.

KLEIN, HAROLD T., Stamford.

KLEIN, JOSEPH, Hartford (Entered service from Brooklyn, N. Y.;) b. 1910, Long Island College of Medicine 1934; Army Air—June 19, 1941 Lt., Captain February 2, 1942, Major July 13, 1943, Lt. Colonel December 20, 1945; Service Terminated February 19, 1946; Duty—Savannah, Ga.; Greenville, S. C.; Barksdale Fld., La.; Awards—Army mendation Ribbon; Letter of mendation.

KLEINMAN, HAROLD L., Bridg (Entered service from New York b. 1913; Buffalo 1941; Army—Ja 1945 Contract Surgeon; Service T nated May 15, 1946; Duty—1223r U. 2nd Service Command; Aw Certificate of Commendation.

KLEMPERER, WOLFGANG W., Haven; b. 1912; Cornell 1936; Ar July 1, 1942 Lt., Captain August Service Terminated February 1946; —5th and 7th Army Medical In tions—North Africa, Italy, France, many, England, Egypt, Palestine (pean-African-Middle Eastern-Me ranean Theatres of Operations); T General Hospital, Ft. Dix, N. J.; Su Generals Library, Washington, D Surgeon Generals Historical Li Cleveland, Ohio; Awards—Bronze Unit Citation, 7 battle stars; (Ren to Seattle, Washington).

KNEPP, JAMES W., Hartford.

KOFFLER, ARTHUR, Stamford.

KONOPKA FRANK J., Walling b. 1906; Georgetown 1931; Army February 25, 1942 Lt., Captain N ber 16, 1942; Service Terminated D ber 18, 1945; Duty—School of Avi Medicine, Randolph Fld., Tex.; Ice England (European Theatre of O tions), Mitchell Fld., N. Y.; Kir Fld., N. M.

KORNBLUT, ALFRED, Bridgepo 1896; New York University 1920; —June 28, 1941 Lt. Comdr., Comm er August 1, 1942, Captain Novemb 1945; Service Terminated Januar 1946; Duty—New London, Conn.; Juan, P. R.; Bainbridge, Md.; St. Al N. Y.; Hunter College, N. Y.; B lyn, N. Y.

KOSTER, LEO W., West Haver 1910; New York University 1937; S. (USCG)—December 20, 1942 Surgeon (R), Past Asst. Surgeon October 11, 1943, Past Asst. Sur Regular Corps July 6, 1945; Sur (T) Regular Corps August 1, Service Terminated September 4, Duty—Boston, Mass.; Philadelphia, Ft. McHenry, Md.; Detroit, Mich.; S Island, N. Y.

T, JOSEPH H., Torrington; b. 1908; York University 1933; Army—ber 26, 1943 Lt.; Service Terminated uary 24, 1945; Duty—Ft. Williams, nad, Me.

FMAN, WILLIAM B., New Haven; 910; Tufts 1935; Army—June 24, Lt., Captain, August 1941, Major, 1942, Lt. Colonel, April 1945; Serv- erminated February 14, 1946; Duty adley Fld., Conn.; European Theatre perations.

SZEWSKI, HENRY W., New Brit-

NSKY, CHARLES M., New London; 908; Tufts 1933; Army—June 4, Lt., Captain June 1, 1945; Service inated November 3, 1945; Duty— sle Barracks, Pa.; 120th Evacuation ital, Camp Shelby, Miss.—Third Seventh Armies, European Theatre Operations; Awards—2 campaign

SNICK, GERALD, New Haven ered service from Philadelphia, b. 1911; Jefferson 1938; Army Air ptember 25, 1940 Lt., Captain Feb- 1942, Major February 1943; Serv- erminated December 5, 1945 (Lt. nel); Duty—Ft. H. G. Wright, N. 57th Fighter Group—Bradley Fld., .—Egypt, Tunisia, Malta, Sicily, Corsica (North Africa-Mediter- an Theatre of Operations); Awards campaign stars; 3 Presidential Unit ions.

SNICK, MORRIS Y., New Haven; 05; Yale 1930; Army Air—Decem- , 1943 Captain; Service Terminated ary 15, 1946 (Major); Duty—Car- Barracks, Pa.; San Antonio, Tex.; ilton Fld, Calif.

NKEL, PAUL, Newington (Entered ce from Brookline, Mass.); b. 1911; ington University 1934; Army— ary 10, 1942 Captain, Major No- er 15, 1944; Service Terminated h 17, 1946; Duty—School of Tropi- Medicine, Washington, D. C.; 105th ral Hospital; 2nd Station Hospital; Station Hospital (Asiatic-Pacific tre of Operations); Awards—3 e stars.

E, GEORGE B., Sandy Hook (En- service from New York City); b. ; Long Island College of Medicine ; Army—October 2, 1942 Lt., Cap- April 1, 1944; Service Terminated January 6, 1946 (Major); Duty—U. S. Army Hospital Ship Blanche F. Sigman; Middle Eastern-European Theatres of Operation; Awards—Presidential Unit Citation; European Theatre Ribbon w/3 battle stars.

LABRECQUE, FREDERICK C., Waterbury; b. 1909; Tufts 1935; Navy—January 10, 1944 Lt., Lt. Comdr. February 1, 1946; Service Terminated March 5, 1946; Duty—Charleston, S. C.; Auxiliary Vessels Ferry Crew No. 2; Shoemaker, Calif.

LABUZ, EUGENE F., Bristol.

LACAVA, JOHN J., New Britain; b. 1910; Georgetown 1934; Army—February 5, 1943 Captain; Service Terminated July 25, 1946 (Major); Duty—Continental United States; European Theatre of Operations; Award — Meritorious Service Plaque.

LAMPSON, RUTLEDGE S., Hartford; b. 1907; Harvard 1934; Navy—May 12, 1942 Lt., Lt. Comdr. March 1, 1944, Comdr. November 5, 1945; Inactive Duty February 6, 1946; Duty—Newport, R. I.; Castine, Me.; Norfolk, Va.; USS Missouri; Awards—Asiatic-Pacific Theatre Ribbon w/3 battle stars.

LANKIN, JOSEPH J., Hartford; b. 1912; Harvard 1937; Army—February 24, 1941 Lt., Captain June 30, 1942, Major February 26, 1946; Service Terminated June 26, 1946; Duty—Camp Blanding, Fla.; Camp Shelby, Miss.; Camp Claibourne, La.; European Theatre of Operations.

LAPALME, JOSEPH A., Putnam (Deceased).

LAPENTA, ROCCO G., Hartford.

LAPIERRE, ARNAUD R., Norwich.

LARKIN, JOHN C., New Britain (Entered service from California); b. 1906; Johns Hopkins 1935; Navy—February 1942 Lt., Lt. Comdr. 1945; Service Terminated February 1946; Duty—Fifth Marine Division—Asiatic-Pacific Theatre of Operations—Japan.

LARSON, ALBERT L., Hartford (Entered service from White Plains, N. Y.); b. 1911; Albany Medical 1936; Army Air —May 15, 1942 Captain, Major January 1943, Lt. Colonel February 1946; Service Terminated April 28, 1946; Duty—School of Aviation Medicine, Randolph Fld., Tex.; Mitchell Fld., N. Y.; Award—Meritorious Service Plaque.

LATAIF, GEORGE, New Milford; b. 1911; Hahnemann 1936; Army—January 20, 1941 Lt., Captain June 22, 1941, Major August 30, 1942; Service Terminated November 27, 1945; Duty—208th General Hospital, Iceland; 113th General Hospital, Persia; Wm. Beaumont General Hospital, Texas; Lovell General Hospital, Fort Devens, Mass.

LAUBE, PAUL J., New Haven (Removed to China).

LAVIETES, PAUL H., New Haven; b. 1907; Yale 1930; Army—August 12, 1944 Lt., Captain September 20, 1945; Service Terminated December 12, 1946; Duty—Veterans Facility, Brecksville, Ohio; Swannanoa, N. C.; Camp Atterbury, Ind.; Award—Unit Citation.

LEBHAR, NEIL F., Westport (Entered service from New York City); b. 1913; Columbia 1939; Army Air—February 20, 1942 Lt., Captain December 1942; Service Terminated February 16, 1946; Duty —School of Aviation Medicine, Randolph Fld., Tex.; Eastern Flying Training Command.

LECHAUSSE, RALPH M., Manchester (Entered service from Blackwood, Va.); b. 1906; Medical College of Virginia 1935; Army Air—March 1, 1941 Lt., Captain February 1, 1942, Major February 7, 1944, Lt. Colonel December 20, 1945; Service Terminated January 25, 1946; Duty—Continental United States; Flight Surgeon—Asiatic-Pacific Theatre of Operations; Awards—Air Medal; Asiatic-Pacific Theatre Ribbon w/6 battle stars; Philippine Liberation Ribbon w/1 star; Pre-Pearl Harbor Defense Ribbon; Presidential Unit Citation.

LEHNDORFF, PETER G., Willimantic; b. 1913; Vienna (Austria) 1937; Army—November 5, 1943 Lt., Captain January 26, 1945, Major June 12, 1946; Service Terminated August 20, 1946; Duty—Carlisle Barracks, Pa.; Camp Rucker, Ala.; Camp Mackall, N. C.; Oahu, T. H.; Koko Head, Fort Hase; New Caledonia; Leyte, P. I.; Ominato Honshu, Japan; Morioka, Honshu.

LENKOWSKI, WILLIAM J., Waterbury.

LENOCI, RALPH J., Bridgeport; b. 1913; Hahnemann 1940; Army Air—September 29, 1942 Lt., Captain February 1944; Service Terminated December 31, 1945; Duty—Robins Fld., Ga.; Alameda, Calif.; Ogden, Utah; School of Aviation Medicine, Randolph Fld., Tex.; San Bernardino, Calif.; Ireland, Scot-

land, England, St. Mere Eglise, LeMans, Dijon, Dole, Beaumont, St. Dizier, France-Belgium (European Theatre of Operations); Awards—Presidential Unit Citation; 5 battle stars.

LEONARD, GEORGE A., Waterbury.

LEONARD, ROBERT J., New Haven; b. 1908; Georgetown 1938; Navy—May 16, 1942 Lt. (j.g.), Lt. March 1943, Lt. Comdr. October 1945; Service Terminated March 3, 1946; Duty—Bethesda, Md.; Parachute Training School, New River, N. C.; Camp Elliott, Calif.; New Caledonia; Vella La Vella; Bougainville; Camp Pendleton, Calif.; Yosemite, Calif.; Guadalcanal; Okinawa; Guam, M. I.; Tsingtao, China (Asiatic-Pacific Theatre of Operations); Awards — Parachute Badge; Bronze star; Navy Commendation Ribbon; 4 battle stars.

LEVIN, ROBERT R., Hartford (Entered service from New York City); b. 1910; Harvard 1936; Army—September 18, 1942 Lt., Captain June 22, 1943; Service Terminated November 30, 1945; Duty—Chemical Warfare School, Edgewood Arsenal, Md.; Invasion of Kiska, Aleutians; Scotland, France, Belgium, Germany; Awards—Asiatic-Pacific Theatre Ribbon w/1 battle star; European Theatre of Operations Ribbon w/3 battle stars.

LEVINE, HOWARD, New Britain; b. 1916; Harvard 1941; Army—August 21, 1942 Lt., Captain January 22, 1944; Service Terminated February 1946; Duty—Camp Edwards, Mass.; 60th Field Hospital—European Theatre of Operations; Awards—Bronze star; European Theatre Ribbon w/5 campaign stars.

LEVY, AARON, Winsted; b. 1904; Tufts 1931; Royal Army Medical Corps—Lt., Captain December 12, 1942; Service Terminated January 3, 1946; Duty—England, India, Burma, Singapore.

LEWICKI, EDWARD S., Waterbury; b. 1906; Georgetown 1935; Navy—January 3, 1944 Lt.; Service Terminated October 16, 1945; Duty—Newport, R. I.; Lido Beach, N. Y.; Plymouth, England; (European Theatre of Operations).

LEWIS, SAMUEL D., Hartford; b. 1908; George Washington 1931; Army—July 1, 1941 Lt.; Service Terminated January 1, 1942; Duty—Camp Claiborne, La.

L'HEUREUX, JEROME A., Meriden; b. 1906; Boston University 1934; Navy—October 23, 1944 Lt.; Service Terminated May 29, 1946; Duty—Davisville, R. I.; USS McCracken, Naval Hospital Base #8; USS Procyon (Asiatic-Pacific Theatre of Operations); Chelsea, Mass.

LIEBERMAN, DAVID L., Chester; b. 1900; New York University 1926; Army—October 2, 1942 Captain; Service Terminated December 23, 1945; Duty—Camp Myles Standish, Mass.; European Theatre of Operations; Ft. Hamilton, Brooklyn, N. Y.

LIEBERTHAL, MILTON M., Bridgeport; b. 1911; New York University 1935; Army—December 19, 1942 Lt., Captain January 1944; Major April 1946; Service Terminated August 5, 1946; Duty—School of Tropical Medicine, Washington, D. C.; Moore General Hospital, Swannanoa, N. C.; Award—Unit Award of Merit.

LIEBOW, AVERILL A., New Haven; b. 1911; Yale 1935; Army—July 15, 1942 Captain, Major January 1944, Lt. Colonel March 1945; Service Terminated October 6, 1946; Duty—39th General Hospital—Camp Edwards, Mass., Camp Stoneman, Calif., New Zealand, Saipan, M. I.; Japan (Joint Commission for Investigation of the Effects of the Atomic Bomb); Army Institute of Pathology, Washington, D. C.; Awards—Citation from CG U. S. Army Forces in Western Pacific; Army Commendation Ribbon.

LINDER, JAMES H., Sharon (Entered service from New York City); b. 1903; Columbia 1927; Army—May 7, 1942 Captain, Major 1946; Service Terminated January 1, 1947; Duty—Camp Upton, N. Y.; Camp Kilmer, N. J.; Rhoades General Hospital, Utica, N. Y.; Alaska (Asiatic-Pacific Theatre of Operations); Tilton General Hospital, Ft. Dix, N. J.; Halloran General Hospital, Staten Island, N. Y.

LINDSAY, MERRILL K., Washington, D. C. (Entered service from Bethesda, Md.); b. 1884; Columbia 1910; Army—July 4, 1944 Captain; Service Terminated May 20, 1946; Duty—Mt. Alto Hospital, Washington, D. C.; (Removed to Washington, D. C.).

LINDSAY, DOUGLAS, North Guilford (Entered service from Louisiana); b. 1919; Yale 1943; Army—2nd Lt., MAC, April 12, 1942, 1st Lt. MC January 12, 1944, Captain October 16, 1944, Major October 4, 1946; Commissioned in the Regular Army, Carlisle Barracks, a Hale, Colorado; Camp Carson, Col a European Theatre; Awards—Silve Bronze star, Purple Heart, Combat cal Badge.

LINDSKOG, GUSTAF E., New H b. 1903; Harvard 1928; Navy—M 1944 Lt. Comdr.; Service Term December 21, 1945; Duty—U. S. Hospital, Philadelphia, Pa.

LIPKOFF, CLARENCE J., Milfor tered service from New York Cit 1911; New York University 1936; —February 7, 1941 Lt., Captain A 1944; Service Terminated Febru 1946; Duty—107th Med. Bn-Cl Co., 32nd Div.; 2nd Field Hospital Port Surg. Hospital; 13th Station pital (Asiatic-Pacific Theatre of tions); Camp Shelby, Miss.; Aw Presidential Unit Citation.

LIPTON, HAROLD, Danbury (E service from Brooklyn, N. Y.); b. St. Louis 1932; Army Air—Decem 1940 Captain, Major December 1, Lt. Colonel September 22, 1945; S Terminated January 12, 1946; D Camp Lee, Va.; School of Aviation cine; School of Tropical Medicine cutta, India; Langley Fld., Va.; grove, R. I.; 23rd Fighter Grou Heavy Bomb. Group; Karachi, (China-Burma-India Theatre of tions); Base Flight Surgeon, Rapid S. D.; Sioux Falls, S. D.; Awards— dential Unit Citation; Asiatic-P Theatre Ribbon w/3 battle stars.

LIROT, STEPHEN L., Meriden; b. McGill 1932; Navy—November 1942 Lt., Service Terminated Ma 1944; Duty—Bainbridge, Md.; Creek, Va.; Bethesda, Md.; C Mass.; Newport, R. I.

LITTER, LEO, Hartford (Entered ice from New York City); b. 1911; (Switzerland) 1936; Army—Janua 1941 Lt., Captain January 24, Major February 23, 1943; Service T nated December 14, 1945; Duty- lisle Barracks, Pa.; Ft. Hancock, 26th Med. Bn., Puerto Rico; 69t fantry Division—Camp Shelby, M England, France, Belgium and Ger (European Theatre of Operati Awards—Bronze star; Meritorious ice Placque; Combat Medical badg

To be Continued

ANNUAL REPORTS
OF THE CONNECTICUT STATE MEDICAL SOCIETY
1947 - 1948
(Continued)

REPORT OF THE CHAIRMAN OF THE COUNCIL

President and Gentlemen of the House of Delegates:

t this meeting it is the duty of the Council to bring to th House of Delegates an accounting of its activities and a omplishments for the period since the mid-winter meeti .

hree meetings have been held and a great deal has been a omplished. All of the problems presented to the Council h e been reviewed, debated and we hope solved.

he Trustees of the Building Fund will make a report t ay. I am at liberty to tell you that the Council has ap- p ved the recommendation of the Trustees that we pro- e d at once to have plans drawn and proceed with the n v building with the funds we have.

We now have 160 student members. This is a program e se to the hearts of all of us. These young members are b ng inculcated with the viewpoints of organized medicine d ing their most formative years. I am sure that the Con- r ticut State Medical Society will reap a rich harvest f m this activity in the years to come.

The Committee appointed one year ago to study the o anization and objectives of the Connecticut State Med- i l Society will make a report today. I know that it has d oted a great deal of time to this project. It is hoped t t their report will include an outline of the finances o the society. The Council is seriously concerned about t s. You will also get a report from the treasurer. From t h you will see that the budget is very close. We are d ing all that we can with the money we have. This is not e ough. We cannot stand still. There are many projects w ich must be started, and soon, if we are to do our full d ty. Our dues of $20 were established in 1943. Obviously m much cannot be purchased in 1948 with the $20 as could b purchased in 1943. I think that great credit is due the s cretary for the way he has handled the office situation u der these conditions.

The Committee on Military History felt that they could n t carry on any longer and the Council has discharged h e committee with thanks for the work they have done a d for what has been accomplished. The editors of the J URNAL, the Secretary, and Dr. Grace Mooney will carry o from here.

Unfortunately the controversial question of the Work- m en's Compensation Law will not be settled today. This is a difficult problem. The Council urges this committee to s y and have a final report for the mid-winter meeting. It might be wise at this time to suggest to the Connecticut S ate Hospital Association and the Connecticut State Nurses Association that a permanent conference committee of 9 members be formed to be made up of 3 representatives of each of these organizations and 3 representatives of the Connecticut State Medical Society to study problems common to all. This would parallel a national committee appointed by the parent organizations and now at work.

Your president, Dr. James R. Miller, retires from official position in this society after this annual meeting. This is unfortunate. He has contributed a great deal to the work of the society for a great many years. The Council feels that this will be a great loss to the Society. Study and thought is being given to some plan to continue him as consultant to the Council. His membership on the Board of Trustees of the American Medical Association adds to his great value for Connecticut Medicine. I feel a great personal loss in his retirement.

The members of the Council have been very faithful to their duties. They have attended the meetings well. You ask much of your councilors in time and effort. Be appreciative of their work.

Again I call to your attention the loyalty of the headquarters staff. Each year my admiration and respect for these people increases. They have carried on under most difficult and trying conditions. Working space is inadequate. At times the office is so crowded that one wonders how anything can be accomplished. Then everything is accomplished. I know it is due to their ingenuity and willingness to work under hardships. Particular praise is due to Dr. Barker's assistants, Dr. Grace Mooney and Mr. James Burch. The Council has seen fit to grant the staff a cost of living increase in salary.

And now I come to the concluding paragraph of this report. You know who and what this is about. You do not know that each year for the past 4 years he has had two tempting offers to go elsewhere. This year is no exception. Appreciate him. He is very loyal.

Respectfully submitted,
T. P. Murdock

SUPPLEMENTARY REPORT — COMMITTEE ON PREPAID MEDICAL SERVICE*

The Committee on Prepaid Medical Service has a deep sense of satisfaction in the action of the House of Delegates in approving a service plan of prepaid medical service to be provided by a non profit organization controlled by the medical profession. It is the type of operation successfully

**All recommendations in this report adopted by House of Delegates, April 27, 1948*

adopted in many states and was the original proposal made by your Committee several years ago.

The Committee is also pleased to note the increased interest in and knowledge of prepayment plans on the part of members of the Society as evidenced by the discussion at the largely attended meetings of the county associations during the past year.

The Society's present committee has made the neeessary technical and analytical studies and endeavored to inform the membership objectively so that it could make its deeision. That deeision has been made today and the way is now open for the development of a non profit serviee and indemnity plan as approved by the House and a eommittee representative of all areas and interests in the state will be required.

Therefore, the Committee recommends to the House of Delegates:

1. That the present Committee on Prepaid Medical Service be discharged.

2. That each county association be requested to name one member of a new State Committee on Prepaid Medical Serviee and inform the secretary of the State Society of the appointments before June 1 of this year. These appointments can be made by the county associations in any way they wish, by the president or governing board of the association or by election in a special meeting of the assoeiation.

3. That as soon as practical after June 1 the president of the State Society shall call the appointed members of the Committee together in its first meeting for the purpose of electing a chairman and seeretary of the Committee and discussion of the Committee's objective. Thereafter, the Committee shall operate on its own initiative and seek such counsel and advice from within and without the State as it may deem desirable.

4. That the Committee may request the Council to call a special meeting of the House of Delegates at any time when the Committee has a plan and method of operation prepared for consideration by the Delegates.

5. That the Couneil be authorized to make available from the funds of the Society a reasonable sum of money for the ordinary operating expenses of the Committee.

6. That when a plan has been devised, approved by the House of Delegates and placed in operation, this Committee shall continue as the Society's representatives in its operation and vaeanices on the Committee shall be filled by appointment by the county association in which the vacaney has oeeurred and the president of the State Society shall at all times be a member of the Committee with privileges equal to all other members of the Committee except he shall not serve as its chairman.

SEMI-ANNUAL REPORT OF THE COMMITTEE ON STUDY OF THE ORGANIZATION AND OBJECTIVES OF THE CONNECTICUT STATE MEDICAL SOCIETY

Mr. President and Members of the House of Delegates:

Onee again, I have the honor to present, for its members, the following report of the Committee on Study of the Organization and Objectives of the Connecticut State M ical Soicety for the period ending April 26, 1948, and c stituting the third interval report of this Committee. Si the last report there has been no ehange in the perso of the Committee.

The task of the group has, in planning and in devel ment, gradually aligned itself into six basie fields of stu viz.,

1. The Organization of the Council.
2. The Committees of the Society.
3. The Journal of the Soeiety.
4. The Organization and Functions of the Central Off of the Society.
5. The Relationship of the Society to the Community.
6. The Financial Structure of the Society.

Of these, the first two are still under consideration; f conclusions and reeommendations have not yet been fo ulated. The study of the other four eategories has been e pleted and is herewith presented.

I. The Journal of the Connecticut State Medical Soci

In his original charge to this Committee, the then pr dent of the Society, Dr. Cole B. Gibson, suggested t such a study should include primarily a "survey of rea interest. Our Journal is much too good to lie unread our members' desks. If a survey reveals that reader inte is not high, what methods are indicated for improving situation?" In its final form the Committee has limited study to such a survey of reader interest. Investigations the history of the Journal, its organizem operation and financial status have been omitted as irr vant to the present study exeept in so far as reference n be made to any of these items in the course of the sur of reader interest.

During the mid-summer of 1947 an explanatory le and attached questionnaire was mailed to 2208 memb of the Society. Within a period of about one month, completed returns were received; this represents 32.7 cent of the members circularized. These replies have b analyzed and the results are tabulated in detail in App dix B.

This gratifying number of serious replies, actually m greater than anticipated, indicates in itself exeellent gen member interest in the Society and the Journal. The lowing conclusions eonstitute a summary of the statist analyses referred to above:

1. The Journal is read, partly or in full, by 91 per e of the members replying.

2. More material in the form of case reports by memb of the Soeiety is requested by 58 per eent.

3. More articles prepared by persons of national re tation are requested by 57 per cent.

4. The editorial opinion expressed is agreeable to 87 cent.

5. No preference for any one department is expres by 70 per cent. Of those expressing a preference, 54 cent were concerned with elinical presentations, 35 per c with specific departments and news and 11 per cent w editorials.

Fifty-one per cent of the replies indicated no desire more comprehensive information from the Secretary's ce; 33 per cent do wish for more and 16 per cent le no reply.

The presentation of Society and County news is pre- ly satisfactory to 58 per cent; 27 per cent desire more s and 1 per cent less news.

News of the Woman's Auxiliary does not interest 71 cent.

The Book Reviews are helpful to approximately 50 cent.

. The Advertising is useful to approximately 50 per t.

1. Suggestions for improving the JOURNAL or comments n the JOURNAL were included in 58 per cent of the lies. Of this group of 422 replies, there were 16 who dissatisfied with the JOURNAL and would prefer to have publication suspended (see Appendix C). The remaining offered a total number of 398 suggestions as indicated Table IV, Appendix B. Of these constructive suggestions, per cent request more clinical material, while the re- nder are diversified.

rom those conclusions it is apparent that reader interest he CONNECTICUT STATE MEDICAL JOURNAL is excellent and t the JOURNAL is well read. The Committee is of the nion that no important changes are indicated and that presentation of clinical articles and material has been should continue to be the primary objective of the torial Board. The Committee is further of the opinion t the financial structure of the JOURNAL represents a ditable record and is sound.

THE ORGANIZATION AND FUNCTIONS OF THE STATE OFFICE

PHYSICAL REQUIREMENTS OF THE EXECUTIVE OFFICE

The present office space of the Society consists of one m of moderate size and one somewhat smaller office. second small office on the opposite side of the hallway rented and maintained by the Connecticut Medical amining Board. The larger room serves as the office the executive secretary and a conference room in which held the regular meetings of the Council and such ever cial committee meetings as may request the space. This not an infrequent situation. If occasion or procedure is h that the executive secretary is not to be included a participant in the meeting, he has no alternative but vacate his office for the period of discussion.

The two smaller offices, one of which is actually not the ciety's, are expected to provide desk space for the execu- e assistant, the public relations officer, two full time nographers and the clerk of the Connecticut Medical amining Board, as well as space to serve as a waiting m and for files and office storage.

At the present writing no lease is held by any tenant in building. There is a persistent, though unconfirmed mor of anticipated purchase of the building by an owner ose interests are not entirely sympathetic towards the ciety.

It is the opinion of the Committee that the physical aracteristics of the present office of the Society are woe- fully inadequate. This is despite the statement of the staff who maintain cheerfully that they "can get along all right" until the new and permanent home for the Society is available. The Committee feels that approximately twice the amount of present office space represents the *minimum* necessity, that a central location is preferable to one more peripherally situated, and that such space should be sought for temporary use during the interval prior to availability of the new building. It is therefore recommended that the Council take such steps as in its opinion are necessary and desirable to alleviate promptly this shortage of space.

B. STAFF AND ASSIGNMENTS

The present staff of the central office of the Society consists of the following:

1 Executive Secretary.
1 Executive Assistant.
1 Public Relations Officer.
2 Secretary-stenographers.

This present staff is technically able and sufficient in size to meet the work load of the office. It is not likely that this staff can efficiently handle any further increase in its required duties. There is a significant trend towards constant increase in the duties, responsibilities and requests made on the time of this present staff. Any further actual increase in the work load will require additional clerical assistance. The Committee recommends that the Council provide, at its discretion and subject to its resources, sufficient additional secretarial assistance.

C. A PLAN FOR RETIREMENT BENEFITS FOR PERMANENT EMPLOYEES

Under his existing contract the executive secretary is provided with the assurance of a retirement annuity plan if he continues in the service of the Society to the age of 65. This arrangement is such that by agreement the annual premium is deducted from his salary and paid by the Society to the insurance carrier. However, under the details of the agreement the premium is actually the property of the secretary, is merely transmitted by the Society as agent and full ownership of the annuity contract rests with the secretary.

No provision exists for retirement income for other full time employees of the Society unless in the form of private contracts unknown to this Committee. The Committee is of the opinion that a responsibility rests with the Society to assist in the provision of certain benefits upon retirement for full time employees of long service. It is further held that such manifestation of good faith on the part of the Society would serve to strengthen the spirit of loyalty so essential in an efficient organization and thereby insure a relative permanence of service. Such provisions for retirement income should be available to employees of proven satisfaction and of specified tenure of office and should in all instances be voluntary on the part of the employee. Therefore, it is suggested that consideration be given to a plan that will incorporate the following features:

1. Eligibility: present employees and future employees after a period of 3 years satisfactory service.

2. Retirement Age: males—65; females—60.

3. Disability Benefits: in the event of disability prior to the date of retirement, benefits should be available to the employee on a prorated scale of the accumulated value and subject to election by the employee.

4. Severance Benefits: to provide for payment to the participant of fractional amounts of the accumulated funds if employment is terminated prior to the retirement age.

5. Death Benefits: optional forms of settlement available to the beneficiary would be:

(a) Annuity Contract: i.e., the cash value or sum paid in would constitute the death benefit.

(b) Retirement Income with Life Insurance: i.e., the face value of the policy ($1000 life insurance per $10 a month pension) would constitute the death benefit.

6. Voluntary participation.

Considering the present number of four full time employees, exclusive of the executive secretary already provided for, retirement benefits equivalent to 40 per cent of their annual salaries can be purchased from commercial carriers for an annual premium of slightly less than 20 per cent of the total annual salaries of these employees or at an actual cost of $2,601.66. Additional provisions for life insurance contracts varying from $6,825 for the lowest income bracket to $16,785 for the highest could be obtained for an additional $120.52 per annum.

It is therefore recommended that:

1. A retirement plan be adopted.

2. The Society bear 50 per cent of the cost of the annual premium or that portion of the annual premium that does not exceed 10 per cent of the employee's annual salary.

3. The Council appoint a Committee, exclusive of employees of the Society, to investigate in detail such plans and present its final recommendations to the Council for execution.

D. COMPENSATION AND PUBLIC LIABILITY INSURANCE

Until quite recently, no provisions existed within the structure of the Society for insurance to cover the costs of competition due to employees who might sustain injuries in the course of their employment for which the Society was legally liable. Within the past four months the executive secretary has concluded negotiations to establish such coverage on the basis of an insurance contract of suitable type.

Similarly, there has been no provision for insurance protection in the category of public liability. This problem has likewise been met by the purchase of a suitable type of public liability insurance coverage.

It is recommended that the Council be authorized to investigate and maintain such insurance coverage and that the status of insurance coverage in these categories be reviewed annually.

E. SOCIAL SECURITY (OLD AGE BENEFIT) AND UNEMPLOYMENT COMPENSATION TAXES.

In the past the Society has held that, under existing law, it was exempt from payment of Old Age Benefit and Unemployment Compensation Taxes by virtue of its charter and by-laws which are so worded as to organize the Society for educational, cultural and scientific purposes on a non-profit basis.

In 1937, a specific request for exemption from payme of Old Age Benefit (Social Security) taxes was approv by the then Collector of Internal Revenue. This corr spondence is on file in the permanent records of the So ety. In reviewing this problem the Committee has conferr with the Society's auditors who were of the opinion th adequate legal exemption has been established and fou no reason to reopen the issue.

To date, it has been the belief of the Society that for t same reasons it was exempt from payment of Unemplo ment Compensation taxes, but has not invited an offici opinion in this respect.

The Committee is of the opinion that the status of e emption from Old Age Benefits tax is clear, a matter record, and that no further inquiry need be made. Ho ever, the Committee recommends, in order to establish t status of exemption from Unemployment Compensati tax as a matter of record, that the Council direct a specif written request for official opinion to the Unemployme Compensation Department at Hartford.

F. ADMINISTRATIVE DETAIL

1. *Transportation.* The activities of the office of the Sta Society are concerned with all geographical areas with the State of Connecticut and, on many occasions, elsewhe and at considerable distances. The necessity for transpo tation is obvious. Once again, this is not a static need b an expanding one and concerns not one but all executiv of the Society. At the present time the only provision f transportation of the executives of the State Society is o of cash reimbursement on a mileage basis for travel in personally owned automobile and for train fare and relate travel expenses. Whenever such expenses are not paid b other participating agencies, they are now paid from a annual allocation of $1,000 included in the executive secr tary's contract; the only exception is the 6 cent per mi reimbursement to the public relations officer for use of h personal automobile which is paid from the budget of th public relations section. This arrangement appears to b inadequate. Therefore, in addition to these existing prov sions, the Committee recommends that the Council b authorized to purchase, for ownership and maintenance b the Society, a suitable automobile for the use of the exec tive officers of the Society in the conduct of its offici business.

2. *Officers of the State Society.* Under the present by laws no provisions exist for the succession of officers in th event of death or incapacity. It is recommended that th Council prepare and present to the next meeting of th House of Delegates such amendments to the present by-law as are necessary so as to provide for suitable and orderl succession of the elected officers of the Society in th event of death or incapacity.

3. *Uniformity of County Association By-Laws.*

It has come to the attention of the Committe that certai discrepancies exist between the by-laws of the several com ponent County Associations and the State Society. Fo example, there is a considerable variation amongst th

unty Associations and the State Society in terms of gibility requirements for membership. There are other nilar contradictory situations. Whereas, the Committee ongly appreciates and approves of the individual autono- of the County Associations, it unhesitatingly urges that herever possible uniformity of method and procedure be ablished. In that sense the Committee recommends that e president appoint a special committee to confer with e presidents of the component County Associations with e hope that they may study and develop procedures which ll obviate these discrepancies.

4. *Inter-Office Procedures between State and County ffices.*

a. Inasmuch as membership in the State Society is based on membership in the component County Associaiton, e application blank for membership emanates from the ice of the secretary of the County Association. For the rposes of that Association certain basic information is quired and there is additional biographical data that might of considerable value; for the purposes of the State office of that information is essential. By virtue of the close operation between the Connecticut Medical Examining oard and the Connecticut State Medical Society, the ecutive secretary has access to pertinent data concerning applicant for membership which might be of interest to e local County Association in considering the applicant. view of the mutual and parallel interests of both County d State offices in consideration of new applicants for mbership, it is the opinion of the Committee that some pe of uniform, duplicate application form with provision r mutual exchange of pertinent information would provide r more efficient processing.

b. In the normal processes of office procedure, items of formation come to the attention of either a county cretary or the executive secretary which would be of utual benefit to the other office. This would include, hong others, such matters as changes in address, changes status and contemplated or effected transfers in member- ip. It appears to the Committee that certain standardiza- n of procedure could be effected which would serve to prove the efficiency of interchange of these matters of cord.

c. In the past it has been customary for the State office to quest a semi-annual statistical report from each compon- t County Association as of the date of its respective semi- nual meetings. Because of the inevitable overlap in the hedule of these several meetings, certain inaccuracies de- lop which are unavoidable. The Committee is of the inion that these reports should be uniformly dated as June 30 and December 31 of each year.

d. Now that the central office of the State Society has ndertaken the task of collection of all dues, both county d state, for 6 of the 8 counties, the problem of report the county associations of dues paid becomes one of in- easing magnitude. It remains essential that the offices of unty secretaries be accurately and promptly informed ncerning these transactions. It is the opinion of the Com- ittee that the office of the State Society should submit a port, as of the last day of each month, of dues paid during at month.

Accordingly, it is recommended that the president appoint a Committee consisting of the executive secretary of the Society, or his representative, and the secretaries of each of the component County Associations to study and effect such of these suggestions as prove practical.

III. The Relationship of the Society to the Community

The broad field of relationship between the Connecticut State Medical Society and the citizens that constitute the community in which we exist can be broken down into two primary categories: viz., participation by the State Society in

a. Fields of allied interest.

b. Publicity.

Throughout the years the Society has continued to expand its sphere of interest and support to many organizations whose activities are allied in some manner with our own. This cooperative effort is in some instances attained by advisory committees from the Society to the neighbor group, in a few instances by joint committee leadership and in still others by individual representation by one or more members of the Society on the governing boards of these allied organizations.

At the present time this participation includes actual representation by one or more members of the Society on some 32 State boards, commissions or the advisory committees of various official agencies, the advisory committees to 11 voluntary agencies of allied interest and one or more members on the directing boards of 15 other agencies. The character and distribution of this participation is indicated by the following tabulation of some of these organizations:

STATE BOARDS, COMMISSIONS AND ADVISORY COMMITTEES TO OFFICIAL AGENCIES

AGENCY	MEMBERS
Commission on Alcoholism	2
State Milk Regulation Board	1
Retirement Commission, Medical Examining Board	3
Public Health Council	2
Humane and Welfare Institutions Building Program Commission	2
Connecticut Medical Examining Board	5
Connecticut Homeopathic Medical Examining Board	3
Connecticut State Board of Examiners in Midwifery	3
Connecticut State Board of Examiners for Physiotherapy Technicians	5
State Water Commission	1
Flood Control and Water Policy Commission	1
Interstate Sanitation Commission	1
New England Interstate Water Pollution Control Commission	1
State Tuberculosis Commission	1
Veterans' Home and Hospital Commission	2
Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm	2
Inter-racial Commission	1
Connecticut State Advisory Council (temporary)	10
Connecticut Veterans' Advisory Commission	1
Board of Trustees of the University of Connecticut	1
Connecticut State Hospital, Middletown	1

AGENCY	MEMBERS
Norwich State Hospital	3
Fairfield State Hospital	2
Joint Committee of the State Mental Hospitals	2
Mansfield State Training School and Hospital	1
Southbury Training School	1
Joint Committee of the State Training Schools	1
Mystic Oral School for the Deaf	1
Board of Pardons	1
Connecticut School for Boys, Meriden	1
Connecticut State Farm for Women, Niantic	2
Long Lane School for Girls	2

ADVISORY COMMITTEES

Medical Advisory Committee of the Institute of Living
Advisory Committee to the Board of Directors of Connecticut Hospital Service
Medical Advisory Committee of the Connecticut Cancer Society
Delegates to the Connecticut Nutrition Council
Medical Advisory Committee to the Veterans' Placement Board
Advisory Committee to the State Department of Health on Psychiatry Clinics
Joint Conference Committee with the Connecticut Pharmaceutical Association
Advisory Committee to the Public Welfare Council on Federal Funds
Advisory Committee to the State Board of Examiners for Nursing
Advisory Committee to the Crippled Children's Division, State Health Department
Advisory Committee to the State Health Department on Evaluation of Serological Tests

VOLUNTARY AGENCIES

Connecticut Children's Aid Society
Connecticut Child Welfare Association
Connecticut Humane Society
Parent-Teacher Association of Connecticut
Connecticut Society for Mental Hygiene
Connecticut Tuberculosis Association
Connecticut Society for Crippled Children
Connecticut Hospital Association
National Foundation for Infantile Paralysis, Connecticut Chapter
Connecticut Cancer Society
Connecticut Public Health Association
American Legion, Department of Connecticut
Newington Home for Crippled Children
American School for the Deaf
Connecticut Home for the Blind

It is the opinion of the Committee that this type of cooperative mutual effort constitutes one of the most significant and effective procedures by which it is being formally demonstrated that the Connecticut State Medical Society, in addition to being vitally concerned with its own particular life and problems, is strongly conscious of its moral, social and professional responsibilities to all other fields of community activity. Such cooperative effort should be fostered studiously and the Society must be constantly ready and willing to lend its support, advice and experience.

Since August of 1946, when a full time public relati officer was added to the permanent staff of the Society, th has been a gratifying expansion in the field of publicity mutual community effort. This department is now resp sible for daily, weekly and monhtly press releases wh during the last nine months of 1947, resulted in amazing total of 2,052 published column inches of ne paper material. In addition to the actual releases for pu cation, the section maintains a regular editorial informat service of authentic and important data which is distribu to all editors. Special releases are prepared for the *Jou of the American Medical Association*, the *Connecti Pharmacist*, and other allied periodicals. Throughout year a weekly newspaper column devoted to matters health has been prepared and released to weekly newspap A regular weekly radio broadcast from four local C necticut stations has been organized and carried out w programs devoted to problems of health and disease. T activities of the public relations section continue throu the form of special services to many of the standing special committees of the Society, the maintenance o speaker's bureau, participation in industrial health conf ences with management and in cooperation with the wh plan for veterans medical care throughout the State.

It is the considered opinion of the Committee that exc lent progress has been made in the field of public relatio Medicine can no longer remain static and passive if it is survive in the form that we know. A partial solution, Committee believes, lies in the active participation in co munity life that this intelligent and forceful progr provides. To date the physical facilities for its possible pansion and efficiency have been limited, particularly respect to office equipment and transportation facilities. is recommended that the public relations section be co tinued and that special attention be directed to its expansi

IV. The Financial Structure of the Society

In terms of a broad general survey of the financial str ture of the Society, the Committee finds that it is sound a adequate. This opinion was corroborated upon consultat with the professional auditors who are familiar with situation.

In general the financial organization is such that treasurer of the Society, through the office of the execut secretary acts as the agent for collection of all funds the Society. These in turn are deposited to the Socie bank accounts where they are supervised by the Seco National Bank of New Haven as Trust Officer. The Ba as trust officer, in turn, deposits to the current active counts for disbursement by the treasurer or his delega representatives in payment of current expenses. The ent operation is subject to continuous as well as annual audit the firm of Seward and Monde.

In consideration of this procedure, certain modificati for the sake of method and efficiency have occurred to Committee. Two specific considerations have significan increased the tasks of the central office: namely,

1. The gradual assumption by the central State office the collection of dues for both County and State Societ This is now true for all but two counties in the State.
2. The gradual but continued general increase in

vities of the Soeiety.

view of these facts, it is entirely possible that in the near future significant revision of the methods and cedure of bookkeeping and record system may be re- ed. It is conceivable that this might entail installation of office and business equipment.

has been noted that in the management of the expenses he JOURNAL, certain sum of money as provided by the get are allocated monthly to the Hartford office of the RNAL for payment of its eurrent expenses and in turn r single entry journal sheet is returned monthly from Hartford offiee to be ineorporated in the overall ac- nts in New Haven to support the alloeations already le to the Hartford offiee. The Committee raises no ieism of the aceuraey nor validity of this aecounting em but in turn questions seriously whether it is a tieal and efficient proeedure. It would appear to be bersome and in some respeets a duplicating meehanism.

speeifie eonsideration of the resourees of the Soeiety the practical relationship of current reeeipts to current ense, the Committee finds that a favorable balance has n maintained eonsistently. It is not only desirable but eed of utmost importance that a signifieant surplus uld not be accumulated over the years in order to avoid ieism or aetual investigation in terms of a non profit anization. Such an eventuality would not only seriously eet upon the Soeiety's integrity in the eyes of the public eritical period for organized medieine but would like- e jeopardize immediately our position as a tax exempt itution. However, the Committee recognizes eompletely eurrently inflated eost of operation, the rapid expansion programs and aetivities of the Society, and the eurrent d of other State Soeieties towards substantial inereases in s. This has varied from as little as $2 in one State to a h of $35 in another; in a reeent survey there were 13 tes with dues already greater than those in Connectieut another 13 States were considering signifieant increases dues rates which are currently lower than those in this te. It seems likely that as the activities and responsibilities the Society continue to increase, there will result an ual need for greater income.

Aecordingly, the Committee recommends that:

. The Council be authorized to institute sueh changes equipment, procedure and personnel as are required to erate and maintain modern accounting methods as recom- nded by suitable agencies and approved by the Council.

. The present "revolving fund" of the Hartford office of JOURNAL and the payment of current accounts in that iee be eliminated by relocation of the account in the office the State Society, that collections formerly made by the rtford office be made through the central office of the eiety and that accounts payable by the Hartford office be ndled by the forwarding of approved vouchers to the ntral office of the Society for processing.

. The basic determination of annual dues must depend on a strict annual budget which shall consider in detail e eost and extent of the Society's anticipated program d the alignment of income to expense.

Respectfully submitted,

Charles G. Barnum — Karl T. Phillips

C. Charles Burlingame — William Schneider
Frank H. Coueh — William M. Shepard
Thomas J. Danaher — Harold E. Spieght
George H. Gildersleeve — Oliver L. Stringfield
Charles T. LaMoure — Herbert Thoms
Arthur B. Landry — Floyd A. Weed
Berkley M. Parmelee — Courtney C. Bishop, *Chairman*

APPENDIX A

SUMMARY OF RECOMMENDATIONS

1. That the Council take such steps, as in its opinion are neeessary and desirable, to alleviate promptly this shortage of spaee (the physical requirements of the State offiee).

2. That the Couneil provide, at its discretion and subject to its resourees, sufficient additional seeretarial assistance.

3. That:

a. A retirement plan be adopted.

b. The Society shall bear 50 per eent of the cost of the annual premium or that portion of the annual premium that does not exeeed 10 per eent of the employee's annual salary.

c. The Couneil appoint a Committee, exelusive of employees of the Society, to investigate in detail sueh plans and present its final reeommendations to the Council for execution.

4. That the Couneil be authorized to investigate and maintain sueh insuranee eoverage (Compensation and Public Liability) and that the status of insurance eoverage in these categories be reviewed annually.

5. In order to establish the status of exemption from Unemployment Compensation Tax as a matter of record, that the Couneil direct a speeific written request for official opinion to the Unemployment Compensation Department at Hartford.

6. That the Council be authorized to purchase, for ownership and maintenance by the Society, a suitable automobile for the use of the executive officers of the Society in the conduct of its official business.

7. That the Council prepare and present to the next meeting of the House of Delegates such amendments to the present by-laws as are necessary so as to provide for suitable and orderly succession of the elected officers of the Society in the event of death or incapacity.

8. That the president appoint a special committee to confer with the presidents of the component County Associations with the hope that they may study and develop procedures which will obviate these discrepances (Uniformity of County Association By-Laws).

9. That the president appoint a committee consisting of the executive secretary of the Society, or his representative, and the secretaries of each component County Association to study and effect such of these suggestions as prove practical (inter-office procedure).

10. That the public relations section be continued and that special attention be directed to its expansion.

11. In respect to the financial structure of the Society that:

a. The Council be authorized to institute such changes of equipment, procedure and personnel as are required to

operate and maintain modern accounting methods as are recommended by suitable agencies and approved by the Council.

b. The present "revolving fund" of the Hartford office of the JOURNAL and the payment of current accounts in that office be eliminated by relocation of the account in the office of the State Society (that collections formerly made by the Hartford office be made through the central office of the Society) and that accounts payable by the Hartford office be handled by the forwarding of approved vouchers to the central office of the Society for processing.

c. The basic determination of annual dues must depend upon a srtict annual budget which shall consider in detail the cost and extent of the Society's anticipated program and the alignment of income to expense.

These recommendations were adopted by the House of Delegates with the exception of the material in parenthesis in recommendation 11b.

Babies Raised by Mail

South Australia has a government subsidized organization known as the Mothers and Babies Health Association by corresponding with which many mothers are able to rear their babies successfully. The Association supplies written lectures to mothers in the State and to isolated areas throughout Australia's 3,000,000 square miles. These lectures include instructions on the correct diet and exercise for mother and baby, general health problems, childhood ailments, and hints on suitable baby clothing.

If mothers live in small country towns trained sisters of the Association offer advice personally and watch the health of growing babies during regular periodical visits. In addition the Association runs two special trains, staffed by sisters, and sidetracked at selected spots for several days until all mothers within a radius of 50 miles have had an opportunity to receive free advice offered by the staff of the train.

Use of Progesterone in Threatened Abortion

S. Bender reporting in the *British Medical Journal** explains the unsatisfactory results which have been obtained in the treatment of threatened abortion with progesterone. He came to the conclusion that, if all cases of threatened abortion are treated with progesterone, 45 per cent will abort, whi none are treated, 41 per cent will abort. If, howe all cases of threatened abortion are subdivi according to their progesterone need, and pro terone if given only when the pregnanediol ex tion is low, only 18 per cent abort and a consider salvage of fetal lives results.

To determine whether or not there is a deficie of progesterone, Bender used the Guterman originally employed as a pregnancy test. pregnanediol excretion test, although less exact t lengthier methods of assay, has been found emin ly suitable for this purpose. It is economical, be completed within 3 hours, does not involve use of experimental animals, and requires but 100 of a first morning specimen of urine.

The results of Bender's investigation suggest t the abortion rate in cases of threatened abort when the fetus is still alive can be reduced by ab 25 per cent by selecting for progesterone ther only those cases in which the Guterman test negative or weakly positive.

*April 10, 1948

Philadelphia Discusses Atomic Energy

About 300 physicians, hospital representati Army and Navy medical personnel, and civili held the first meeting of its kind at the Pennsylva Hospital in January to discuss atomic energy. T president of the American Medical Association a officers of the Philadelphia County Medical Soci spoke, but the chief speaker of the evening ca from the Surgeon General's Office.



WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

resident, Mrs. Charles W. Goff, West Hartford
President-elect, Mrs. Ralph L. Gilman, Storrs
Vice-President, Mrs. F. Erwin Tracy, Middletown
Second Vice-President, Mrs. Charles H. Sprague, Bridgeport
Recording Secretary, Mrs. Paul Vestal, Woodbridge
Treasurer, Mrs. Frank DiStasio, New Haven
Corresponding Secretary, Mrs. J. Whitfield Larrabee, West Hartford

h ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION, JUNE 21-25, 1948, CHICAGO, ILLINOIS, HOTEL LA SALLE

Information

A most cordial invitation is extended to all women, who are Auxiliary members or guests of physi- s attending the convention of the American Medical Association, to participate in all social functions attend the general sessions. Whether Auxiliary members or not, the wives of doctors will be most come.

Auxiliary headquarters will be on the mezzanine floor of the Hotel LaSalle. All meetings and functions be held at the Hotel LaSalle unless otherwise stated in the program, or announced during the meet- Please register early and obtain your badge and program of the social function.

All tickets should be purchased soon after arrival. These will be sold at the Auxiliary headquarters. meetings and social affairs will begin at the time scheduled. Please be prompt.

Registration Hours

Sunday	2:00 P. M. to 4:00 P. M.
Monday	9:00 A. M. to 4:00 P. M.
Tuesday	9:00 A. M. to 4:00 P. M.
Wednesday	9:00 A. M. to 4:00 P. M.

Mrs. Joseph H. Howard and her committee are be congratulated for the attractive setting in ich the annual meeting of the Woman's Auxiliary he Connecticut State Medical Society took place. oklawn Country Club, Bridgeport.

The beautiful day, artistic surroundings and many ght spring hats gave a "Blythness of Spirit" to occasion, even though Dr. Creighton Barker e all credit to the fact that we were meeting in dgeport.

Our president, Mrs. Robert J. Cook, graciously sided and introduced each guest in her usual mitable manner, remarking to Dr. Barker that did not realize that Bridgeport was the "Paris" Connecticut.

Dr. James Raglan Miller expressed some very ttering and well received remarks about the excellent choice in wives of the Connecticut State Medical Society. He then gave a resumé of some of the issues being discussed at the medical conferences.

The newly elected president of the Connecticut State Medical Society said that he was "Exhibit A"—to be seen and not heard. We were delighted to have Dr. Samuel Harvey with us.

Mrs. Cook then called upon Dr. Ralph L. Gilman, chairman of the Advisory Board, who congratulated the Woman's Auxiliary for their success "in spite" of the Advisory Board.

Dr. Harry Pennington was also present. Dr. Pennington has been a member of the Advisory Board for one year and hopes that we will feel free to bring our problems to the Board at any time. (Do you suppose that Dr. Pennington suspects that we have problems?)

Our guests from the Woman's Auxiliaries of our neighboring States gave most interesting accounts of the activities in their own organizations. The doctors in New York State seem to take more than an active interest in the Woman's Auxiliary. It sounded wonderful.

The guest speaker of the afternoon, Dr. Joseph S. Lawrence, director, Council on Medical Service, Washington, D. C., gave a delightful prelude to his talk "The Washington Picture" by painting a word picture of flowering Washington at this time of year. Dr. Lawrence then proceeded to enlighten us on the more serious side of Washington.

A business meeting followed and reports of officers and standing committee chairmen were read and accepted.

The chairman of the Nominating Committee, Mrs. James Douglas Gold, presented the slate for 1948-1949.

Following are the newly elected officers: President, Mrs. Charles W. Goff, West Hartford; President-elect, Mrs. Ralph L. Gilman, Storrs; First Vice-President, Mrs. F. Erwin Tracy, Middletown; Second Vice-President, Mrs. Charles H. Sprague, Bridgeport; Recording Secretary, Mrs. Paul Vestal, Woodbridge; Corresponding Secretary, Mrs. J. Whitfield Larrabee, West Hartford; Treasurer, Mrs. Frank DiStasio, New Haven.

Mrs. Charles W. Goff, newly elected president, took the chair and announced that we would be pleased to hear that she was not going to make a speech. Mrs. Goff said that she was honored by her new position and thanked the membership for their confidence in her. She then immediately went to work by calling an Executive Board meeting, following the adjournment of the annual meeting.

The Woman's Auxiliary to the Connecticut State Medical Society extend congratulations to Mrs. Goff and wish her every success.

Hartford County

Over 100 members attended the 4th Annual Meeting of the Woman's Auxiliary to the Hartford County Medical Association, which was held on April 6 at the Hartford Golf Club. At the business meeting the annual reports of the various committees were presented. In the president's report, the main activities of the Auxiliary were summarized: (1) the printing of the year book, (2) the formation of a Scholarship Fund, (3) a benefit concert, (4) a legislative meeting, (5) a rummage
(6) the creation of a welfare project.

The election of the following officers then t
place: President, Mrs. Ralph T. Ogden; Presid
elect, Mrs. Ralph A. Richardson; First Vice-P
dent, Mrs. E. M. Andrews; Second Vice-Presid
Mrs. Louis H. Gold; Corresponding Secretary, M
Harvey B. Goddard; Recording Secretary, M
Edwin C. Higgins; Treasurer, Mrs. James R. Cul

Following the social hour Mrs. Robert C
State president, spoke briefly. Mrs. Paul S. Ph
then presented the "Past President Pin" to M
Paul W. Tisher, the outgoing president.

After dinnner Dr. Howard W. Haggard spok
us, his topic being "Modern Problems of Alcol
ism." Dr. Haggard's talk was not only stimulat
but extremely enlightening. He stated that
eventual solution to the problems of alcoholism
in education and when the nation's youth come
look on drunkenness as an outrage. Of the e
mated 60 million people in the U. S. who drink
million are alcoholics. Of these 20 per cent
symptomatic drinkers, 30 per cent are those w
can "take it or leave it," but prefer to take it, a
50 per cent are the alcoholics, who cannot dr
moderately. It is this last group that is taken c
of in the Yale School of Alcohol Studies and Y
Clinics for Alcoholics. Dr. Haggard said that
average age of alcoholics at the Clinic was 47, l
now is 32, which shows that more people are int
ested in preventive treatment. He also pointed
that the National Committee for Education on A
coholism has set up committees in 27 States to spr
information on alcoholism. This is done by inform
tion centers, workers and clinics.

Middlesex County

A luncheon meeting of the Woman's Auxiliary
the Middlesex County Medical Association w
held at the Edgewood Club in Cromwell on Ap
20 with 25 members in attendance. The preside
Mrs. Edgar Yerbury, presided at the business me
ing. Annual reports were given by Mrs. F. Erw
Tracy for the Membership Committee, Mrs. C
Wganer for the Legislative Committee and M
Julius Grower for the *Hygeia* Committee. M
Walter Nelson gave a report on the Auxiliary
work in connection with the Christmas gift proje
for the Connecticut Society for Mental Hygie
The question of projects for the coming year w
then brought before the members and after disc

n it was decided that the primary interest of the xiliary lay in the fields of mental hygiene and gislature. Mr. Francis Russell, executive secretary the Joint Committee of the State Mental Hosals, was introduced and spoke concerning the ientation class to be held on May 5 at the Conecticut State Hospital in Middletown for members the New Haven and Middlesex County Auxilies. The group was then entertained by a cartoonwho drew a number of sketches, including veral one-minute drawings of members present.

New Haven County

The Connecticut State Hospital in Middletown nducted a one-day clinical orientation course in ntal health for members of the Woman's Auxily to the Connecticut State Medical Society on ay 5.

The program began with registration in the medl library at 9:30 o'clock followed by a discussion "Mental Hygiene Problems" by Dr. Yerbury, perintendent of the institution. At 10:00 o'clock . Charles Russman presented cases illustrating ganic mental disorders. Following this, Dr. Benmin Simon, clinical director, discussed "Physchonic or Functional Mental Disorders" and presented ses for discussion.

Following luncheon the study group visited ected areas of the Hospital and reconvened in e medical library at 2:30 o'clock to hear a lecture Miss Helen Forst, senior phychiatric social orker.

The clinical course concluded following a roundble discussion by the auxiliary and members of e hospital staff.

New London County

Mrs. Julian G. Ely of Lyme was elected president the Woman's Auxiliary to the New London unty Medical Association at the Annual Meetg, April 14, following a luncheon at Edgemere anor, Stonington. Mrs. Ely has chosen "A Student urse's Fund" as an Auxiliary project, whereby me worthy young woman who cannot pay tuition ay enter nurses' training at the W. W. Backus ospital, Norwich, or at the Lawrence and emorial Associated Hospitals, New London.

Officers elected with Mrs. Ely are: President-ect, Mrs. Winfield Kelley, Uncas-on-the-Thames; ice-President, Mrs. Frederick B. Hartman, New London; Secretary, Mrs. Harold Higgins, Norwich; Treasurer, Mrs. Joseph C. Woodward, New London.

Members of the Auxiliary were asked by Mrs. Ely to go to the State Hospital at Preston, May 6, for a tour of the hospital, lunch and a round table discussion to determine if the Auxiliary may help this institution in any way.

The membership was urged to attend the State meeting in Bridgeport.

Mrs. Hewes as retiring president heard and accepted reports of officers and committee chairmen and thanked them for their cooperation.

A donation of $50 will be made to the Eleanor Mercer Wellington Memorial Fund.

The guest speaker Dr. William Goodrich, radiologist of Hartford, gave a technical history of x-ray and radium.

Forty-eight members from Norwich, Niantic, Lyme, Mystic, Stonington and New London attended the meeting.

Mrs. Walter Lukoski, chairman of public relations, has submitted the following report: The first meeting for the members of the Speakers Bureau of the Woman's Auxiliary was held at the New Haven City Medical Library with Dr. Joseph H. Howard of Bridgeport as lecturer. Dr. Howard stated that in many parts of the country the fact must be faced that "there is unequal and inadequate medical care." We as Auxiliary members should strive for the best way of providing a healthier community.

The purpose of the Speakers Bureau is to help the people of this State understand the accomplishments and aims of American Medicine and to provide speakers for local small groups.

The following have expressed their willingness to be placed on the Speakers Bureau: Mrs. Julian G. Ely, R. F. D. 2, Lyme, and Mrs. E. Roland Hill, 43 East Main Street, Mystic. We have urged every member of the Auxiliary to help carry out this program by answering this appeal as speakers are needed in every area.

Auxiliary members who live in different towns have been asked to help by contacting leaders in their own communities to arrange at least one health program for the 1948-49 season.

Project: Health day program before summer, one to be held in Norwich and one in New London.

The Woman's Auxiliary to the New London County Medical Association entertained the doctors at a formal dinner dance April 21, Lighthouse Inn, New London. The evening was most enjoyable and 68 attended. Congraulations to Mrs. Eric H. Blank of New London and her committee who were in charge of arrangements.

Windham County

The annual meeting of the Woman's Auxiliary to the Windham County Medical Association was held at the Mansfield School. It was a most interesting session. The nominating committee presented the following slate which was accepted: President, Mrs. William Mac Shepard; Vice-President, Mrs. Kenneth Kinney; Treasurer, Mrs. Karl Phillips; Secretary, Mrs. Cecil Garcin.

Sheets of proposed projects were discussed and given to the members to be gone over, marked and returned.

A cafeteria lunch was served. Nothing special or different. The Auxiliary wanted to learn as much as possible about the school and how the patients live. The same type of lunch was served to the Auxiliary members as to the hospital employees.

The doctors, nurses and various specialized workers were introduced.

Following lunch the homes were visited, also various shops and the hospital. The shops included those used for printing, making brooms, shoe repairing, making of mattresses and the laundry. All the work is done by patients, who are taught the various skills. One is amazed at the perfection shown. Wards at the hospital were visited and many of the cases were seen.

An excellent minstrel show was put on by the patients. It was a most interesting experience and one long to be remembered. The Auxiliary is very grateful to Dr. Watson for this very fine opportunity.

A "Health Fair" was given at Putnam by the Woman's Auxiliary to the Windham County Medical Association. There was a Health Program Exhibit and a discussion of local health matters. A most interesting talk was delivered by Dr. Theodore Steege, the title "Heart Disease." The exhibitors were Girl Scouts, Boy Scouts, Red Cross, 4-H Clubs, Visiting Nurse, Day Kimball Hospital, Windham County Medical Association, P. H. S. Health Education Department.

REPORT OF THE COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Paid Members

COUNTY	1947	NEW MEMB
Fairfield	110	20
Hartford	272	90
(44 reinstated)		
Litchfield	45	8
Middlesex	51	13
New Haven	197	13
New London	63	8
Windham	20	
Total	758	152

Meriden Group—Organized 1946, Chapter of Woman's Auxiliary to the New Haven County Med Association. Mrs. Raymond Quinlan, president. Memb ship 60. Three meetings this year (speakers). Cooperat with County projects; gifts to mental hospital patie nurses recruiting program.

Local Projects—Books, materials to Undercliff Sanitoriu cash gift to Meriden Hospital Nurses fund.

Waterbury Group—Organized 1946. Not associated w the County Auxiliary. Mrs. John Foster, president. Me bership 78.

Local Projects—Four meetings this year.

1. Educational—speaker on literature.
2. Social—mid-winter dance.
3. Business and Fashion Show.
4. Annual meeting plus two short plays.

Mrs. Charles W. Goff, *Chairman*

REPORT OF THE COMMITTEE ON HYGEI

The following is a table showing the county quotas a the number of *Hygeia* achievement points for the vari counties for 1946-47 and 1947-48.

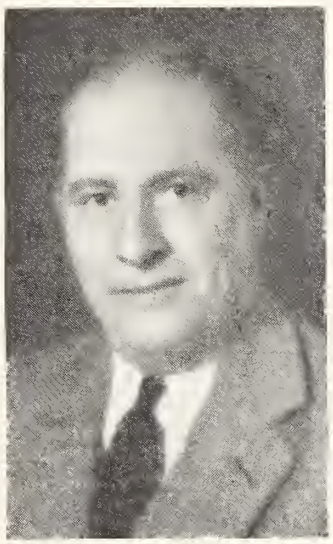
COUNTY	QUOTA 1946-47	NUMBER OF ACHIEVEMENT POINTS 1946-47	QUOTA 1947-48	NUMBER O ACHIEVEME POINTS 1947-48
Fairfield	90	3	111	4
Hartford	137	66	256	57
Litchfield	37	0	49	33
Middlesex	38	14	49	12
New Haven	181	91	207	245
New London	55	100	74	54
Windham	21	2	22	37

This table shows a 60 per cent increase for 1947-48 compared to last year in placements of *Hygeia* througho the state. There was active participation of all organiz counties for the first time. New Haven County exceeded quota to such an extent that it won the third prize for class in the National *Hygeia* Contest. One other count Windham County, did a splendid job in exceeding its quo

Mrs. Dewey Katz, *Chairman*

OBITUARIES

Ralph Edward McDonnell, M.D.
1894 - 1947



Ralph Edward McDonnell died suddenly on ovember 24, 1947. He had been ill for some weeks evious to this but that his end should come when did was unexpected.

With his passing this Association lost its president d one of its most interested members, for Ralph cDonnell was not only interested in medicine but so in medical affairs. He served diligently on many mmittees of the New Haven Medical Associaon, the New Haven County Medical Association, d the Connecticut State Medical Society. He was r many years financial secretary of the New aven Medical Association, was chairman of the ction on Dermatology and Syphilology of the tate Society, served as clerk of the New Haven ounty Medical Association and at the time of his eath was president of this Association.

Born on January 26, 1894, Dr. McDonnell reeived his education in the public schools of New Haven, Yale College, and the Yale School of Medine from which he graduated in 1920. He studied ermatology at the Vanderbilt Clinic in New York ity, became clinical assistant in dermatology at he Yale University School of Medicine, was successively promoted to clinical instructor, assistant linical professor, and finally associate clinical professor in 1936. He was also consultant in dermatology at the Department of University Health, attending physician in dermatology at the Grace-New Haven Community Hospital, University Service and Grace Hospital Service, attending dermatologist to the Hospital of Saint Raphael, as well as consulting dermatologist to several smaller hospitals in the communities near New Haven.

Dr. McDonnell served in both World Wars, with the Army in the first and with the Public Health Service during the second.

Connecticut medicine in general and this Association in paritcular have suffered a great loss. We can ill afford the passing, at such an early age, of a man of such friendliness, cheerfulness, ability and usefulness. There is scant comfort in the knowledge that the manner of his death spared him a great deal of suffering.

The New Haven County Medical Association acknowledges its sense of loss and extends its sympathy to his family.

Maurice J. Strauss, M.D.

Jerome Stuart Chaffee, M.D.
1873 - 1947

Dr. Jerome Stuart Chaffee, a former president of the Litchfield County Medical Association, died at the age of 74 at his home in Sharon on November 26, 1947 after a lingering illness. He was born in Amenia, New York, the oldest child of the union of Lydia Judd of Kent and James Stuart Chaffee, and the first of his family to be born outside of Sharon in three generations. He prepared for college at Wilbraham Academy, and graduated from Yale, the Sheffield Scientific School, in 1894, and from the University of Pennsylvania Medical School in 1897. There he was a founder and president of Nu Sigma Nu fraternity. In the Spanish-American War he served as an ensign in the Navy under Admiral Dewey in the insurrection of the Philippines, and did shore duty under General McArthur, Sr. He later enlisted in the Army and was graduated from the Army Medical School in Wash-



JEROME STUART CHAFFEE, M.D.

ington, D. C. in 1902, studying there under Reed and Carroll.

From 1903 on, Dr. Chaffee practiced in Sharon where he organized the Sharon Hospital in 1909 and laid the cornerstone for the present plant in 1915, now a living memorial to his many years of faithful service to his community. From the beginning, he was chief of the medical staff and secretary-treasurer and later president of the Board, and remained so during his lifetime. Dr. Chaffee was a member of the American College of Surgeons, and also of the Medical Society of the State of New York, the latter recently honoring him on the occasion of being fifty years a physician. He served as health officer, medical examiner, and New York Central Railroad surgeon for over forty years. He was a member of the Military Order of Foreign Wars, the Litchfield County University Club and the Yale Club of New York City.

Dr. Chaffee leaves his widow, Grace Ketcham Chaffee. He had no children and gave his heart completely to the hospital which he fathered for so many years, and which, as children do, brought him both joys and sorrows. The people of Sharon have lost an honored man, and in their mourning have named the original hospital building the Jerome Stuart Chaffee Memorial Pavillion in the present expansion program, the completion of which he was unable to see.

G. S. Gudernatch, M.D.

Dr. Blake Honored by A. A. P.

Francis G. Blake of New Haven was elected pr- dent of the Association of American Physicians t the closing session of the Society's 61st annual me- ing at Atlantic City on May 5.

At the same session Warfield T. Longcope, f- merly professor of medicine at Johns Hopki, received the George M. Kober Medal for his o- standing contribution to medicine and medi education.

New Medical Center at University of Pennsylvania

The University of Pennsylvania Medical Sch has plans for a new $10 million medical cent designed to give Philadelphia one of the natio outstanding centers for medical education, researc preventive medicine, and care of the sick. $1 milli has been contributed to the Philadelphia Medic Center by the Donner Foundation, Inc. toward t construction of a Group Diagnostic Out-Patie Clinic on condition that construction of the ou patient building is started by May 1949.

In addition to a nine-story outpatient buildi there will be an inpatient unit, eleven stories hig which will increase the Hospital's present b capacity to 1,000, and a nine-story Nurses Hon containing 368 student rooms, classrooms, labor tories, library and other facilities for the School Nursing.

Takes Up Post as Assistant Secretary of AMA

Dr. Ernest B. Howard has taken up his duties a assistant secretary of the American Medical Ass ciation. He occupies offices adjoining those c Secretary George F. Lull in Chicago headquarter

Since December 1945, Dr. Howard served a director of the health mission to Peru, South Amer ica, of the Institute of Inter-American Affairs withi the Department of State.

Dr. Howard was graduated from Harvard Colleg and from Boston University Medical School, 193 and from the Harvard School of Public Health 1941. He once served as director of the Division o Venereal Diseases in the Massachusetts Departmen of Public Health, and during most of the war h served as assistant director of the Division o Venereal Diseases in the Surgeon General's Offic of the U. S. Army.

SCHEDULE OF TUMOR CLINICS IN CONNECTICUT HOSPITALS

OSPITAL	DOCTOR IN CHARGE	DATE OF CLINIC	CONFERENCE	X-RAY AND RADIUM	PATHOLOGIST
B kus (Norwich) D & T.†	Robert R. Agnew	1st, 3rd, 4th Wed. at 10 A. M.	None	135-200 kv 70 mgm.	Maurice Moore
B lgeport D & T.	Irving B. Akerson	Follow up: 3rd Fri. New Cases: 2nd, 4th Fri. at 11 A. M.	C.P.C.at 12:15 P. M. every Fri.	200 kv 860 mgm.	Irving B. Akerson
B tol D	Hyman Winters	New cases and follow up being seen →	Last Sat. every mo. 11 A. M.	None	Hyman Winters
C rlotte Hungerford (orrington) D & T.	Francis Sutherland	New cases seen both ward and private →	3rd Sat. every mo. 10 A. M.	200 kv	Lincoln Opper
D bury D & T.	John Booth	2nd Fri. 10:30 A. M. 4th Fri. 10:30 A. M.	None	200 kv	Dr. McIlroy
D Kimball (Putnam) D	Gerald Chartier	4th Mon. 10:30 A. M.	None	None	Robert Tennant
G ce (New Haven) D & T.	Wm. Mendelsohn	Each Tues. 11 A. M. 3rd Tues. Gyn 11 A.M.	None	200 kv x-ray 100 mgm. rad.	Charles Bartlett
G enwich D	Sydney Thompson	2nd and 4th Tues. at 10 A. M.	None	None	Louise Larrimore ?
G ffin (Derby) R cording Clinic Only	NO CLINIC				Charles Bartlett
H rtford D & T.	Robert Tennant	Each Fri. 10:30 A. M.	Each Fri. 12 noon	100 kv 200 kv x-ray 300 mgm. rad.	Ralph E. Kendall Robert Tennant Perry T. Hough
L wrence Memorial (ew London) D & T.	George Cheney	1st, 3rd Fri. 9:30 A. M.	None	200 kv Radium contemplated	Dr. Massig
L chfield County (/insted) D & T.	Lincoln Opper	New cases—ward and private seen →	2nd Fri. 10 A. M.	200 kv	Lincoln Opper
M nchester D	Edward L. Besser	2nd Mon. 11 A. M.	None	None	Ralph E. Kendall Perry T. Hough
M riden D	Allan Ryan	2nd, 4th Sat. 10 A. M.	None	135 mgm. rad.	Rolf Katzenstein
M. Sinai (Hartford)	NO CLINIC				Abraham Schaeffer
M nicipal (Hartford) D	Austin Kilbourn	3rd Sat. 11 A. M.	None	None	Hartford Hospital
M ddlesex (Middletown) D & T.	Carl Harvey	1st Wed 9:30 A. M.	1st Wed. 11 A. M.	200 kv	Christie McLeod
N w Britain General D & T.	Paul D. Rosahn	1st, 3rd Fri. 10 A. M.	None	200 kv x-ray 165 mgm. rad.	Paul D. Rosahn
N w Haven D & T.	Max Taffel	Mon., Wed., Fri. every week, 9 A. M.	Each Tues. 1:30 P. M.	100 kv } x-ray 200 kv } 100 mgm. rad.	Harry Green
N rwalk Hospital & T.	Louis Simon	Each Tues. 11 A. M.	None	200 kv 100 mgm. rad.	Roy Barnett
S Francis (Hartford) & T.	Louis P. Hastings	Each Wed. 11 A. M.	None	200 kv x-ray 100 mgm. rad.	Louis P. Hastings
S Josephs (Stamford) & T.	George Harrison	None	None	None	None
S Marys (Waterbury) & T.	Andrew Jackson	2nd, 3rd, 4th, Wed. at 11 A. M. → 1st Mon. 11 A. M.	Wed. 11 A. M.	200 kv 100 mgm. rad.	Marcus Cox
S Raphaels (New Haven) & T.	Edward E. Allen	Each Tues. 10 A. M.	Each Tues. 11 A. M.	200 kv 100 kv	Robert R. Nesbitt
S Vincents (Bridgeport) & T.	H. R. DeLuca	2nd, 4th Tues. 11 A. M. →	2nd and last Tues. every mo. (dry)	200 kv	Horatio DeLuca
S amford & T.	Edward C. Rawls	Each Tues. 10 A. M.	2nd, 4th Mon. 4 P. M.	200 kv	Jeff Snavely
W aterbury & T.	Joseph Collins	1st, 2nd, 3rd Fri. 10:30 A. M.	Fri. 11:30 A. M.	200 kv 100 mgm.	Joseph Collins
W indham Community (Willimantic) & T.	Edward J. Ottenheimer	1st Mon. 10:30 A. M.	None	200 kv } x-ray 100 kv } 70 mgm. rad.	Robert Tennant

D Diagnostic. †T. Therapeutic. → means clinic and conference are combined.

Above list accurate as of 3-25-48
N. William Wawro, M.D.

SPECIAL NOTICES

NATIONAL REHABILITATION CONFERENCE

The First Annual Conference of Region I (New England States and New York State) will be held at the Hotel Charles, Springfield, Massachusetts, June 9.

There will be addresses by Holland Hudson of the National Tuberculosis Association, Temple Burling, M.D., of the National Committee for Mental Hygiene, Leo Alexander, M.D., associate director of research at the Boston State Hospital, Michael J. Shortley, director of the Office of Vocational Rehabilitation in Washington, and Donald Covalt, M.D., of Bellevue Medical Center, New York City. Each paper will be followed by discussion.

There will be no registration fee.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The 14th Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, June 17-20. There will be papers by leading authorities in this field, Council Luncheon Meetings each day, and Round Table Luncheons on June 18, 19 and 20. Also on June 21, 22 and 23 clinics will be held at the Alexian Brothers Hotel, the Congress Hotel, the Educational Research Hospital, the Cook County Children's Hospital, the Navy Pier and the Hotel Sheraton.

On Thursday, June 24, there will be a Session on Diseases of the Chest for the newly created Section on Diseases of the Chest in the Scientific Assembly of the American Medical Association. This will include a Symposium on Streptomycin.

All physicians are invited. No registration fee.

NATIONAL CONFERENCE OF COUNTY MEDICAL SOCIETY OFFICERS

Sunday, June 20, 1948, 10:00 A. M. to 4:00 P. M.
Palmer House, Chicago

THE JOB OF THE COUNTY MEDICAL SOCIETY
(Three Panel Discussions)

Moderator: A. M. Mitchell, M.D., Terre Haute, Indiana

1:30 P. M.
Registration

2:00 P. M. to 2:45 P. M.

I. The County Medical Society—Its Part in Medical Organization
- A. Relation to the State Medical Association
- B. Relation to the American Medical Association
- C. Relation to Other Medical Organizations—N. P. C., A. A. P. S., Blue Cross, A. M. C. P., Academy of General Practice, etc.

Discussant: F. J. Holroyd, M.D., Princeton, West Virgi
(15 Min.)
Question and Answer Period

2:45 P. M. to 4:00 P. M.

II. The County Medical Society—Its Responsibility to t Membership
- A. Organization Responsibilities
  1. Membership—Selection and Maintenance
  2. Censorship—Maintaining Ethics
  3. Hospital Relations

Discussant: T. J. Danaher, M.D., Torrington, Connecticut
(12 Min.)

- B. Scientific Programming

Discussant: C. J. Milling, M.D., Columbia, South Carolina
(12 Min.)

- C. Fellowship and Business
  1. Social Functions—Golf, Bowling, Parties
  2. Business Aids—Credit and Collection, Telepho Answering Service, etc.

Discussant: C. L. Mulfinger, M.D., Los Angeles, Californ
(12 Min.)
Question and Answer Period

4:00 P. M. to 5:30 P. M.

III. The County Medical Society—Its Responsibility t the Public
- A. Medical Care—Serving the Public
  1. Pay Patients
  2. Medically Indigent
  3. Indigent—Government Clients

Discussant: D. B. Wiley, M.D., Utica, Michigan
(15 Min.)

- B. Community Agencies—The Growing Demand These Agencies Requires Serious Consideration
  1. Special Programs—Participation in Cance Tuberculosis, Heart, etc., programs
  2. Community Chest—The Place of the Medic Profession in the Drives for Funds
  3. Health Councils—The Function of the Medic Society

Discussants: W. E. Nissen, M.D., Albuquerque, New Mexic and B. O. Mork, Jr., M.D., Worthington, Minn
(10 Min. each)

- C. Newspapers, Radio, Industry, and Labor

Discussant: John D. Bibb, M.D., Reno, Nevada

- D. Legislative-Political Responsibilities of the Count Medical Society

Discussant: R. B. Robins, M.D., Camden, Arkansas
(10 Min.)
Question and Answer Period



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IT MAY BE your conscience speaking.

It may be saying: "Save some of that money, mister. Your future depends on it!"

Listen closely next time. Those are words of wisdom. Your future—and that of your family—*does* depend on the money you put aside in savings.

If you can hear that voice speaking clearly, do this:

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There's no better, no surer way to save money. Surer because it's automatic . . . better because it pays you back four dollars for every three you invest.

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Remember—better *save* than *sorry!*

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THE AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY

The next regular meeting of The American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery will be held at The New York Academy of Medicine Building, New York City, on Thursday, June 10, 1948 at 8:00 P. M. Programs may be obtained by writing to the secretary, Dr. Norman N. Smith, 291 Whitney Avenue, New Haven, Connecticut.

GOLF TOURNAMENT

The American Medical Golfing Association will hold its 32nd Tournament on Monday, June 21. The famous beautiful and sporty Olympia Fields has been reserved for the medical golfers' tournament. Dinner will be held in Olympia Fields C. C. Clubhouse, after which prizes will be awarded.

TWO EIGHTEEN-HOLE COURSES

Olympia Fields Country Club has two eighteen-hole courses which are ideal for experts and a treat for players with higher handicaps. Fellows may tee off between 7:30 A. M. and 2:00 P. M. Luncheon will be served at the Club. The Golfers' Banquet will be held at 7:00 P. M. Entertainment will follow the awarding of prizes.

TROPHIES AND PRIZES

Trophies will be awarded for the AMGA championship (36 holes), the Will Walter Trophy; the runner-up champion, the Detroit Trophy; the eighteen-hole championship, the Golden State Trophy; the runner-up eighteen-hole champion, Ben Thomas Trophy. The Section Event will include sterling silver pitchers for eight sections including internal medicine, surgery, gyn.-obstetrics, dermatology-syphilology, radiology, general practice, pediatrics, and eye-ear-nose and throat, and urology. The first flight (0-13) will contain trophies and prizes for both gross and net in 36 and 18 holes including the St. Louis Trophy, the President's Trophy, the Atlantic City Trophy and the Sperry Trophy. The second and third flights (14-18 and 19-30) will contain prizes for both 36 and 18 holes.

The maturity event, for Fellows 60 years and older, the Minneapolis Trophy; the Old Guard Championship, the Wendell Phillips Trophy. In addition to those, approximately 75 other prizes will be in competition.

CHICAGO COMMITTEE ON ARRANGEMENTS

The Chicago Committee on Arrangements is under the chairmanship of Charles E. Shannon, M.D., 104 South Michigan Avenue, Chicago. He will be assisted by Drs. Robert Cummings, J. F. Delph, Frank Fowler, F. P. Hammond, Robert Hawkins, J. H. Hutton, G. E. Johnson, H. E. Mock, H. K. Nicoll, H. P. Saunders, Paul Vermeren.

APPLICATION FOR MEMBERSHIP

The Chicago Tournament will give an opportunity to old and new Fellows to enjoy a wonderful day of golf, to win a nice prize, and to join in the famous Good-Fellowship of the American Medical Golfing Association.

All male Fellows of the American Medical Association are cordially invited to become Fellows of the American Medical Golfing Association; write Secretary Bill Burns, 2(Olds Tower, Lansing 8, Michigan, for application blank.

Participants in the tournament are required to pres their home club handicap, signed by the Club Secretary or to accept a handicap set by the AMGA Handicap Co mittee. No handicap over 30 is allowed. All 18 hole troph and prizes are awarded on the basis of scores for the first holes played. A Fellow absent from the annual banquet f lowing the tournament forfeits his rights to a trophy prize.

AMGA OFFICERS

Waltman Walters, M.D., Rochester, Minnesota is Pre dent; W. C. Speidel, M.D., Seattle, Washington, is First Vic President and Director of Handicaps; Jean A. Gruhl M.D., Atlantic City, is Second Vice-President and Direct of Arrangements. President Walters anticipates that appro mately 300 AMGA Fellows will play in the enjoyab Chicago tournament of Monday, June 21.

FIRST INTERNATIONAL POLIOMYELITIS CONFERENCE

Twenty international medical and scientific authoriti will present papers on poliomyelitis at the First Internation Poliomyelitis Conference in New York City July 12-17.

Speakers and titles of their papers follow:

Dr. Albert B. Sabin, professor of research pediatric University of Cincinnati, Cincinnati, Ohio, "Epidemiologic Patterns of Poliomyelitis in Different Parts of the World."

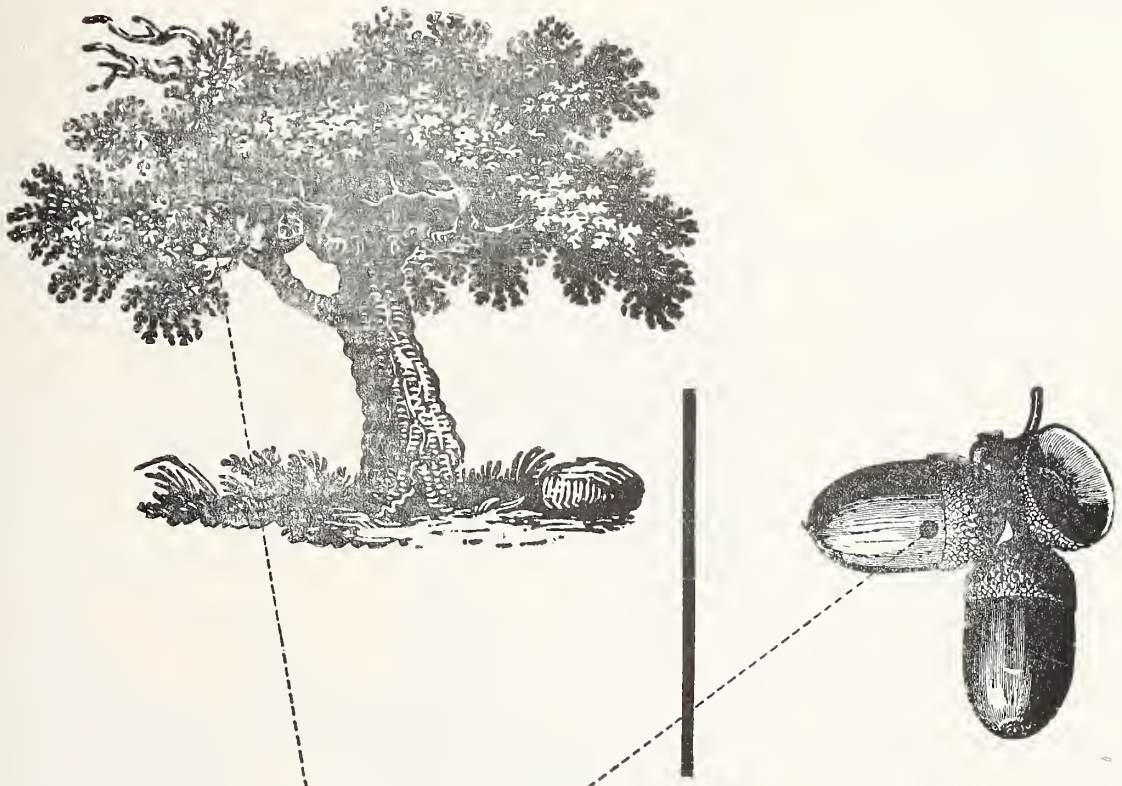
Professor H. J. Seddon, medical director, Wingfiel Morris Orthopaedic Hospital, Oxford, England, "Econom Aspects of Management of Poliomyelitis."

During the session on the early stage of poliomyeliti delegates will hear three speakers—Dr. Irvine McQuarri head, Department of Pediatrics, University of Minnesot Minneapolis, Minn., "The Evolution of Signs and Symp toms;" Dr. David Bodian, associate professor of epidem ology, The Johns Hopkins University, Baltimore, Md., "Th Pathological Anatomy," and Dr. Fritz Buchtal, directo Institute of Neurophysiology, University of Copenahge Copenhagen, Denmark, "The Pathological Physiology."

Dr. John A. Anderson, head, Department of Pediatric University of Utah, Salt Lake City, Utah, will discuss "Diag nosis and Treatment" in the management of the diseas during the early stage.

Three speakers will discuss the convalescent stage of polio myelitis—Dr. E. T. Bell, professor of pathology, Universit of Minnesota, "Progressive Pathology;" Dr. Arthur L. Wat kins, chief of physical medicine, Massachusetts Genera Hospital, Boston, Mass., "Progressive Disabilities;" and Dr Ralph K. Ghormley, consultant on orthopedic surgery a Mayo Clinic, Rochester, Minn., "Progressive Deformaties."

Dr. William T. Green and Dr. Joseph S. Barr, both clini cal professors of orthopedic surgery at Harvard University Boston, Mass., will present papers on management of th



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disease. Dr. Green's paper will be on the convalescent stage of the disease and Dr. Barr's on the late stage.

Three authorities will be at the speaker's rostrum for the session on bulbar poliomyelitis. They will be Dr. K. T. Neubuerger, professor of pathology, University of Colorado, Denver, Colo., "The pathology;" Dr. A. B. Baker, professor of neurology, University of Minnesota, "The Diagnosis;" and Dr. James L. Wilson, professor of pediatrics and communicable diseases, University of Michigan, Ann Arbor, Mich., "The Treatment."

Presenting papers on immunology and chemotherapy in the disease will be Dr. Isabel M. Morgan, assistant professor of epidemiology at The Johns Hopkins University, "Mechanisms of Immunity in Poliomyelitis;" Dr. John R. Paul, professor of preventive medicine, Yale University, New Haven, Conn., "Immunogenic and Other Types of Poliomyelitis Viruses," and Dr. Raymond N. Bieter, professor of pharmacology, University of Minneosta, "Experimental Chemotherapy."

There will be three speakers at the session on public health aspects of epidemic poliomyelitis. They will be Dr. Joseph G. Molner, Deputy Commissioner of Health in Detroit, Mich., "Public Health Measures;" Dr. C. W. Munger, director, St. Luke's Hospital, New York City, "Hospitalization;" and Elizabeth P. Rice, director of social service, Grace-New Haven Community Hospital, New Haven.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-sixth annual scientific and clinical session September 7, 8, 9, 10 and 11 inclusive, at the Hotel Statler, Washington, D. C. Scientific and clinical sessions will be given the days of September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 7, 8, 9 and 10. These courses will be offered in two groups. One set of ten lectures will be based primarily on physics and physiology and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapists. The physical therapists must be registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

MOTION PICTURE FILM CATALOGUE

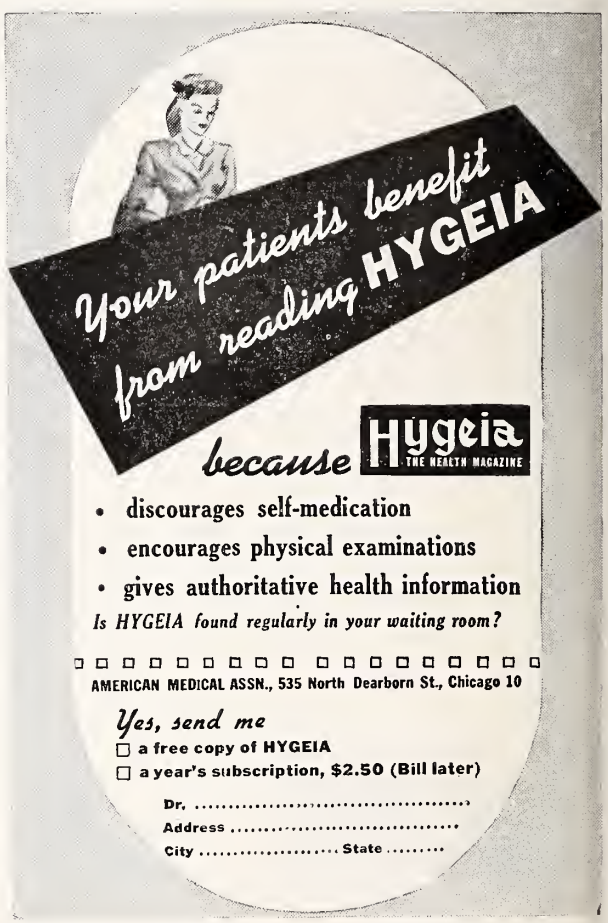
Because of the widespread interest shown in the first edition of the Academy's Film Catalogue by university faculty, program chairmen, Fellows and others, which was demonstrated by hundreds of letters of appreciation, the Academy has compiled a completely revised and greatly expanded second edition.

CATALOGUE OF PROFESSIONAL MOTION PICTURE FILMS

The Academy has for the first time compiled a compr hensive catalogue of surgical, medical and dental film alphabetized both as to classification and titles, which w enable you to locate, select and secure pertinent films. It limited in extent only by the number of films on whic information was provided and contains a number of foreig films. In a section devoted to Audio-Visual Services a announcements of new developments and other data whic might interest those who are building programs.

As a service to the profession the Academy is offering mail, upon request, a complimentary catalogue to all AM officials, deans of medical schools, state secretaries, sta program chairmen, authors of listed films and to certa foreign libraries. Copies will be provided to others, upo request, until the supply is exhausted.

Requests should be addressed to: Academy-Internation of Medicine, Department of Audio-Visual Aids, 214 W Sixth Street, Topeka, Kansas.



Experience is the Best Teacher



Paul Ehrlich
(1854-1915)
proved it in chemotherapy

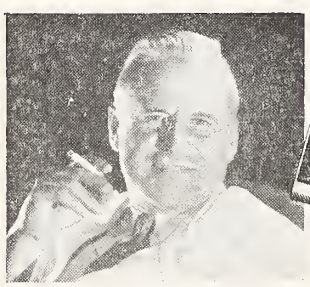
Paul Ehrlich, expanding on his knowledge gained as a pupil of Koch, concluded from his experiences in the staining of bacteria that there was a close chemical affinity between the cellular body and the stain. This idea led him to believe that specific drugs could be found which would kill invading pathologic organisms, without damage to the host. His conclusions helped create the science of chemotherapy, which is increasingly important today.

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Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

OUR NEIGHBORS

Massachusetts

The Council of the Massachusetts Medical Society in February voted to employ a full time secretary for the Society. The Council also approved in principle the transfer of the program for the provision of a whole blood and blood fractions from the Massachusetts Department of Public Health to the American Red Cross, the Medical Society and the Department of Public Health to serve in an advisory capacity.

New Jersey

Royal A. Schaaf, president of the Medical Society of New Jersey, has called upon all the physicians in his State to urge upon the Governor, the Legislature, and Rutgers University the need for a medical school in New Jersey. The Board of Trustees of the Medical Society of New Jersey has already endorsed the principle of "an approved school of medicine under University auspices supported by revenue from general tax funds." Rutgers University is now in process of expanding and augmenting its existing facilities by the expenditure of $15 million in the near future, with a total of $50 million contemplated as a long range program.

New York

The Socony-Vacuum medical department has just moved into new quarters at its 26 Broadway headquarters in New York City, where it utilizes 2,500 square feet of floor space for its activities, which include x-ray, electrocardiograph and basal metabolism units, and a completely equipped laboratory. Its staff of an associate doctor, three nurses, a secretary, two stenographers, a laboratory technician and an x-ray technician is directed by Dr. A. E. Hoag, medical director, a veteran of 30 years with the company.

NEWS
from County Associations

Fairfield

John G. O'Connell, a practising surgeon in Bridg port until his retirement about a year and a ha ago because of illness, died in Hartford on April Dr. O'Connell had been a member of the Bridg port Hospital staff for many years.

Robert H. Noonan and Cyril C. Blaney hav been appointed as ambulance physicians to th Bridgeport Emergency Hospital and City Dispe sary.

George Kraus has been appointed full time healt officer of Fairfield. A graduate of Long Island Co lege of Medicine in 1944, Dr. Kraus entered th Army two years ago after serving his internship ar medical residency at Gouverneur Hospital, Ne York. He served with a rank of captain in th Public Health branch with civilians at Fort Ja N. Y.; Fort Sam Houston, Texas; Fort Bragg, N. C and Charleston Ordnance depot, S. C. He was di charged from service in February. Dr. Kraus r ceived a master's degree in biochemistry at Brook lyn College in 1941, is a diplomate of the Nation Board of Medical Examiners and intends to seek degree in public health at Yale University.

* * * *

Clifford D. Moore, Stamford Hall, Stamford, w elected president of the Fairfield County Medic Association at its 156th annual meeting. Oth officers elected were: William Curley, Sr., vic president; George A. Buckhout, secretary; Clifto C. Taylor, treasurer; Berkley M. Parmelee, cou cilor. Joseph J. Smith of Bridgeport and Russe Keddy of Stamford were elected to the Board Trustees.

Several points of important business were con pleted at the business meeting. The Plan for Pr Paid Medical Care, as usual, brought out a gre



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deal of discussion which was aided greatly by the clear cut picture painted by Frederick H. Elliott, director of the United Medical Service, New York, New York. Dr. Elliott has had many years of experience in this field and, therefore, was able to answer many of the troubling thoughts as expressed. Fairfield County favorably acted upon a Prepaid Medical Care Plan and instructed its delegates to support it at the House of Delegates.

Twenty-eight applicants for membership in the Association were favorably acted upon.

The outgoing president, J. Grady Booe gave an excellent paper on "The Care of Rectal Fistulae."

After an excellent dinner, the Honorable Brien McMahon, U. S. Senator from Connecticut, gave a talk on "Atomic Energy." The interesting question and answer period which followed proved the clarity of the Senator's speech and also the interest stirred up among the men present.

Hartford

The 156th annual meeting of the Hartford County Medical Association was held at the Hunt Memorial Building on April 6. The meeting was called to order at 4:15 P. M. Annual reports were presented and the matter of prepaid insurance was discussed and the Association was placed on record as being in favor of a plan such as recommended in the revised report of the Committee.

The following officers and delegates were elected for the 1948-1949 year: President, Charles T. Schechtman, New Britain; Vice-president, Harvey B. Goddard, East Hartford; Secretary-Treasurer, W. Holbrook Lowell, Jr., Hartford; Censors, John E. Darrow, New Britian, and William H. Upson, Suffield; Public Policy and Legislation Committee, Philip F. Parshley, Hartford; Delegates to State Society, Isadore S. Geeter, Hartford, James E. Stretch, Simsbury, Armanno W. Ciccarelli, Bristol; Philip J. Moorad, New Britain; George A. F. Lundberg, Manchester; John N. Gallivan, East Hartford. Twenty-seven applicants were admitted to membership.

A dinner was held at the Hartford Club. In the absence of Mr. Thomas J. Dodd, Colonel Richard W. Owen gave some of his "Observations Prior to and During the Nüremberg Trials."

The meeting was very well attended and as a matter of fact was the largest in several years. It is very gratifying to see the renewed interest in th County events.

* * * *

Owen L. Murphy, selected as the "Man of th Year" by his fellow townsmen in Simsbury, w honored at a dinner given him recently by th Rotary Club. He was presented a scroll.

Millard Knowlton, formerly director of Bure of Preventable Diseases of the State Department Health, died suddenly in Hartford on May 4. H had retired from active life in 1946.

Litchfield

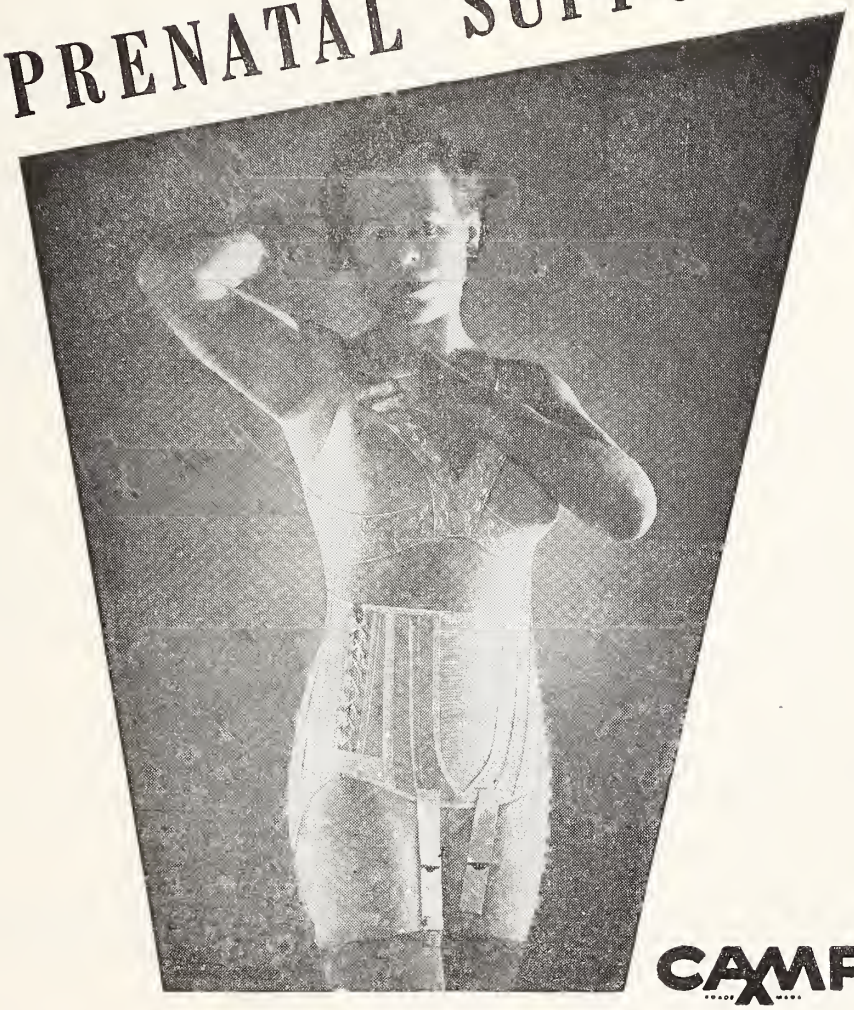
At the annual meeting of the Litchfield Count Medical Association held in Torrington on Apr 14 the following officers were elected: Presiden Frank L. Polito, Torrington; Vice-president, Fran D. Ursone, Norfolk; Secretary-Treasurer, Thom J. Danaher; Councilor, W. Bradford Walker; Cen sor, William G. H. Dobbs, for 3 years; Committe on Ethics and Deportment, Floyd A. Weed, chai man, Richard I. Barstow, Edwin G. Reade, Donal W. Herman, C. Norton Warner, Jr.; Committee o Public Policy and Legislation, W. Bradford Walke chairman, Gaert S. Gudernatch, Roy V. Sanderso State Delegates, Thomas J. Danaher, Richard Barstow, John F. Kilgus, Jr.

Maurice H. Bisharat of Torrington, and Georg A. Fowler of Sharon, a transfer from the Medic Societies of the County and of the State of Ne York, were elected to membership.

James R. Miller of Hartford outlined the activitie of the State Committee on Prepaid Medical Car There followed a quite lengthy discussion. It w finally decided to endorse a prepaid medical pla which included the service and indemnity feature It was considered advisable, however, to recommen that the income level for single persons be $2,00 and for married persons $3,000 a year. The Associa tion also voiced its disapproval of a 50 per cen increase in the schedule of indemnities above thos previously reported. The delegates were unin structed beyond the fact that they knew the genera feeling of the Litchfield County Medical Associa tion.

The Committee on the Organization and Objec tives of the County Association, which has bee working since the semi-annual meeting, gave rather comprehensive report which was discusse fully. For the most part the changes suggeste

PRENATAL SUPPORTS



CAMP

Of the so-called minor complaints of pregnancy, a contributor to the medical literature* makes the following statement concerning backache –

"Backache seemed to be due to several causes. Strain of the lumbar muscles and the vertebral ligaments, due to a change in the center of gravity was often responsible; fallen arches aggravated the complaint. It was relieved by rest in bed. A maternity corset with moderately rigid stays in the back was of benefit . . . Sacro-iliac relaxation as evidenced by pain over the joint was usually unilateral and was referred along the sciatic nerve. Usually a maternity corset would relieve it. This corset should have a strap or other device that will pull it snug over the sacro-iliac region."

Charles J. Marshall, New York Journal of Medicine, Vol. 34, Aug. 15, 1934

Camp prenatal supports are unique in that the overstrap with its buckle (through which the lacings ply) allows the support to be drawn evenly and firmly about the pelvis; thus the pelvic joints are protected and steadied.

From such a foundation, the back of the patient is well supported and the abdominal muscles are aided in holding the increasing load in position.

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apparently met with the approval of the members. The committee was instructed to make such changes in the by-laws as the adoption of their suggestions would necessitate, and prepare this to be voted upon at the next meeting.

Winfield E. Wight gave a very interesting and enlightening presidential report on the subject of "Thrombophlebitis and Phlebothrombosis" and summarized the results of treatment at the Waterbury Hospital.

New Haven

William T. Salter of New Haven addressed the recent meeting of the American Association for the Study of Goiter held in Toronto, Canada, on "Tracing the Thyroid Hormone in Peripheral Tissues."

"'Rooming-In' Gives Baby a Good Start" by Edith B. Jackson of New Haven is the title of the leading article in the April issue of *The Child*, a monthly publication of the U. S. Children's Bureau.

Albert I. Robbins, clinical instructor in orthopedic surgery at Yale and a practicing orthopedist in New Haven, died at Beth Israel Hospital, Brookline, Massachusetts on April 14 after a long illness.

Victor Alexander Kowalewski of West Haven died at his home on April 3 after an illness of 6 years. He had served as medical examiner for West Haven and Orange for about 35 years.

John P. Peters of New Haven has accepted an appointment to Walter P. Reuther's UAW-CIO Health and Medical Care Advisory Committee. This advisory committee will assist the union in development of policies and plans for administration of the hospital and medical care program which is a major part of the current economic demands of UAW-CIO.

Jacob Saltzman of Waterbury has been appointed to the American Board of Dermatology.

Leo J. Tylec of Naugatuck has been named physician in charge of the urology clinic at St. Mary's Hospital, Waterbury.

Fessenden N. Otis, for 28 years roentgenologist at Meriden Hospital, will resign that position as of July 1.

The regular meeting of the New Haven Medical Association was held on May 5, 1948. The guest speaker was Dr. David J. Graubard, chief of anesthesiology, Post Graduate Hospital, New York. Dr. Graubard spoke on "The Management of Arthritis by Means of Intravenous Procaine." I also showed a very excellent film on the preparati of Novocaine, application and cases that we treated with Procaine.

There has been marked increase in the number conferences and this has been so in all three Ne Haven Hospitals during the past six months. T house staff at Grace Hospital has been giving a ve interesting bi-monthly series of talks on vario surgical subjects illustrated with motion pictur Attendance has been very satisfactory and the hou officers have enjoyed this series of instructi sessions.

* * * *

The 164th annual meeting of the New Hav County Medical Association was held at the Ne Haven Country Club on Thursday, April 22. T Association voted favorably for the election of new members, bringing the active total membersh to 728. Frank Hartman and Duncan McDouga both from New London County, were the on delegates present.

Cole B. Gibson, chairman of the Committee Revision of the By-Laws, presented a report of t committee in the form of a complete rewriting the by-laws. Action will be taken on these revisio at the semi-annual meeting in October.

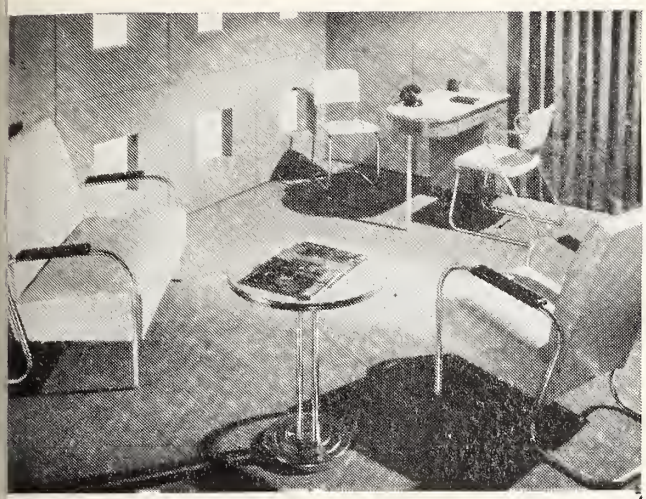
Officers elected for the year 1948-1949 wer Samuel B. Rentsch, president; James Gettings, vic president; Courtney C. Bishop, councilor; an Robert H. Jordan, clerk.

Major Douglas Lindsay, MC-USA, assistant pr fessor of military science in the Yale School Medicine, brought before the Association the ne for Army medical officers.

The speakers of the evening were James C. M Cann and Charles G. Hayden, respectively preside and medical director of the Massachusetts Bl Shield (plan for prepayment medical service) wh discussed in detail the basic principles and oper tional methods of that plan. Considerable intere was shown by the number of members who di cussed the plan. The meeting was climaxed by vote of the Association that its delegates to th House of Delegates of the Connecticut State Med cal Society be instructed to endorse a plan similar the Massachusetts one.

* * * *

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nan was elected chief of staff and Dr. A. J. Jackson chief of surgery.

New London

Casimir V. Belecki of Norwich is taking a special three months' course in obstetrics at the Margaret Hague Hospital, Jersey City. He will resume practise about July 1.

The recently donated blood bank by the Norwich Chapter of Elks is rapidly nearing completion at the W. W. Backus Hospital. When finished it will furnish a much needed must for this vicinity.

On Thursday, June 3, the New London County Association will complete its year of meetings with a most interesting program and an outstanding speaker from Boston. Paul Younge of that city will address the Association on a most timely and important subject, "Early Symptoms and Signs of Cancer of the Cervix." In this day of cancer consciousness, it is most important that all physicians recognize early the lesions that could be cured or, at least, arrested. The meeting will be held at Uncas-on-the-Thames at 8:30 P. M. A most cordial invitation is given all physicians who may be in the vicinity of Norwich on June 3.

John B. Raymer has resumed practice following a lengthy absence, the result of an accident early in January. Save for a little overweight, John looks none the worse for the experience. He is a most welcome addition to our medical and surgical community.

Tolland

Dr. E. Harrison Metcalf, who has retired as health officer for the City of Rockville after more than 25 years of service, has received a letter from Dr. Stanley H. Osborn, Commissioner of Health for the State of Connecticut, commending him for the high standard which he has set in his position.

Dr. Osborn says: "You are indeed to be congratulated on the fine job you did in watching over the public health of the residents of the City Rockville for the past quarter of a century, and feel certain the local people are also appreciative your many efforts in the past to see that they a their families shared in the advantages gained your experienced activities in this field."

Tribute has also been paid Dr. Metcalf by M Frances Parker, senior nurse of the Rockville Pub Health Nursing Association, for the high degree cooperation which she and her predecessors ha received.

During the period which Dr. Metcalf served health officer there has been no serious epidemic Rockville. A program of immunization and innoc lation has practically wiped out contagious disea The result has been that some younger doctors ha never seen a case of diphtheria.

Dr. Metcalf was appointed as health officer r long after he started his practice in Rockville, f lowing service in World War I. He served co tinuously in this post until the first of this month.

Windham

The 157th annual meeting of the Windha County Medical Association was held in Willima tic, at the Nathan Hale Hotel, at 5:30 P. M., Thu day, April 15. The meeting was well attended. T scientific program consisted of a paper on t "Diagnosis and Treatment of Hyperthyroidism" W. T. Vanderlaan, M.D., assistant professor medicine at the Tuft Medical School and physici to the Pratt Diagnostic Hospital, in Boston. T new officers elected were: Reuben Rothblatt, Wil mantic, president; David H. Bates, Woodstoc vice-president; Brae Rafferty, Willimantic, cle and Karl T. Phillips, Putnam, councilor.

There were 3 new members elected to the Win ham County Medical Association at its annual spri meeting: Leo Gerald La Palme, Putnam; Walt Rowson, Jr., Putnam; Bruce Roberts Valenti Abington.



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News from Yale University School of Medicine

John R. Paul, professor of preventive medicine, presided at the Section on Bacterial and Spirochetal Diseases of the Fourth International Congress on Tropical Medicine and Malaria held in Washington in May. The meetings were sponsored by the Department of State in collaboration with other agencies of the United States Government and scientific societies to encourage and facilitate the pooling of useful knowledge for the prevention and treatment of tropical diseases. Such an international congress was long overdue and since new knowledge and methods have been developed since the last meeting in 1938, particularly during the war years, it was more needed than ever before.

* * * *

Six members of the Urological Service of the Yale University School of Medicine participated in three national scientific meetings during April and May.

Clyde L. Deming, clinical professor of urology, delivered the Robert V. Day lecture at the western section conference of the American Urological Association at the Empress Hotel, Victoria, British Columbia. His topic was "The Correlation of Clinical Experience and Experimental Heterologous Growth of Human Prostatic Cancer."

Dr. Deming, John B. Goetsch, research fellow in surgery, and Frances D. Humm, research assistant in pharmacology attended the American Association of Genito-Urinary Surgeons' meeting at Skytop, Pa., May 10 to 12.

Representatives of the Urological Service at Yale presented a scientific exhibit and Dr. Deming reviewed a paper at the annual meeting of the American Urological Association in Boston, May 17 to 21.

Dr. Deming discussed the paper by Drs. Francis J. Twinem and Alfonso Davalos of New York on "Radical Surgery in Prostatic Carcinoma" at the Association's session May 20.

An exhibit on the heterologous transplants of human prostatic cancer was given by Dr. Deming, John B. Goetsch, and Michael S. Hovenanian, instructor of urology.

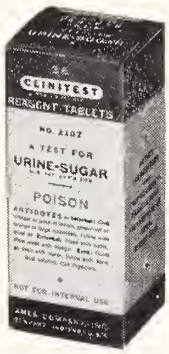
Also representing Yale at the Urological Association's annual meeting was Ralph H. Jenkins, associate clinical professor of urology, and Gertrude Van Wagenen, research associate in obstetrics and gynecology.

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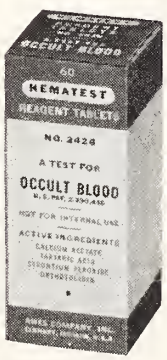
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NEW BOOKS IN REVIEW

PRACTICAL OFFICE GYNECOLOGY. By Karl John Karnaky, M.D., Assistant Professor of Clinical Gynecology, Baylor University College of Medicine; Gynecologist to Jefferson Davis Hospital, Houston, Texas; Director of Menstrual Disorder Clinic, Jefferson Davis Hospital; On Courtesy Staff of St. Joseph Infirmary, Memorial Hospital, Hermann Hospital, Heights Hospital, Park View Hospital and Methodist Hospital, Houston, Texas. *Springfield, Illinois: Charles C. Thomas.* 1947. 261 pp. $7.50.

Reviewed by STANLEY B. WELD

It is difficult to wax enthusiastic over this book. The title might better be stated "The Estrogen Treatment of Gynecologic Diseases," since estrogen therapy plays the major part in the author's armamentarium. Almost everything is treated with estrogen, even as a preoperative measure in the surgical conditions. No space is allotted to emphasis of the necessary careful history nor to the different phases of a careful gynecologic examination.

The volume is a small one and is replete with drawings, photomicrographs, black and white and colored photographs. The latter are borrowed from two leading pharmaceutical houses which explains their lurid colors.

Excessive use of frequent douches is recommended. The use of streptomycin in granuloma inguinale is not mentioned, probably due to the fact that the text was written before this antibiotic came into use. Stilbestrol is advocated in the treatment of hyperplasia of the endometrium but is not mentioned as a valuable factor in alleviating the pain in varicose veins in pregnancy. The use of the stem pessary in dysmenorrhea will receive little support by many gnyecologists.

Perhaps the best chapter in the book is that contributed by Louis Spivak on "Some Psychological Aspects of Gynecology." This chapter instead of being relegated to the back of the book might have been more complete and placed in a more prominent place.

There are many medical gynecologies, office gynecologies, and endocrine gynecologies on the shelves today. This text stands out because of the author's unconventional opinions as different from the others and for this reason should be consulted but never accepted as delineating the only course to follow in treating office gynecologic patients.

YOU AND YOUR DOCTOR. By Benjamin F. Miller, M.D., Clinical Professor of Medicine, George Washington Medical School; Research Associate in Medicine, National Research Council; formerly associated with the University of Chicago Clinics and the United Public Health Service. *New York: McGraw-Hill Book Co.* 1948. 183 pp. $2.75.

Reviewed by STANLEY B. WELD

This book offers an amazing collection of ideas compressed within a few pages. It must have been conceived during a period of inactivity, possibly while recovering from an illness. At first reading it sounds very much like the dream of a feverish brain, but closer study will co vince one of the sincerity of the author and of the soun ness of much of his reasoning. He was born 30 years t soon and may be a prophetic voice "crying in the wilde ness."

The principal theme discussed is group practice and l way of introduction the opening chapter is devoted to description of the typical day of a general practitione Major surgery, obstetrics, minor medical ills—almost ever thing but refraction of eyes and removal of a brain tumor were on the schedule. The general practitioner's dilemn is portrayed and the truism that there is a need for in provement in the methods of the distribution of medic care accepted. Then comes the solution, the Pilot Physicia "Somewhere between the too specialized specialist ar the too unspecialized general practitioner, there is a ne type of family doctor. I call him the 'pilot physician'."

The remainder of the volume develops the theme group medical practice with a pilot physician include This is not socialization. Medical care should be availab to everybody (true). A community health program shoul be developed. Physicians should be examined periodicall as to their ability, not just once, and the incompeter thrown out. Every one should have a physicial examinatio periodically by a group. Post-mortems should be done o all but the exceptional case under the law. Federal suppo of medical education as well as research is a must. (Thi undoubtedly is coming but the question is, how will i come?). Interstate medical care should be set up an financed by the federal government so that an asthmatic i Massachusetts may move to Arizona and be assured of job. There should be a national disaster service, and th United States Public Health Service, *reorganized*, is bes equipped to administer national medical care to includ preventive clinical and research programs.

Read it. You will be surprised—and impressed.

THE FOOT AND ANKLE—THEIR INJURIES, DIS EASES, DEFORMITIES, AND DISABILITIES. (Third Edition.) *By Philip Lewin*, M.D., F.A.C.S., Professor o Bone and Joint Surgery and Acting Head of Department Northwestern University Medical School; Professor o Orthopedic Surgery, Postgraduate Medical School, Cook County Hospital. *Philadelphia: Lea & Febiger.* 1947 847 pp., 389 illus. $11.

Reviewed by BURR H. CURTIS

This is the third edition of this book. The author has made many revisions, most of which are the result of advance in use of chemotherapy and treatment of foot and ankle conditions, both traumatic and otherwise, as experienced in the recent World War. The references are rather extensive and well chosen.

The previous editions of this book, and of course the present one, constitute what is probably the most thorough coverage of treatment and diagnosis of problems arising in the foot and ankle. The author's approach is practical as well as being very detailed. The principal fault in this work is the fact that there is an attempt made to cover such a wide field that, at times, only superficial coverage can be given, but on the whole the most important phases are well presented.

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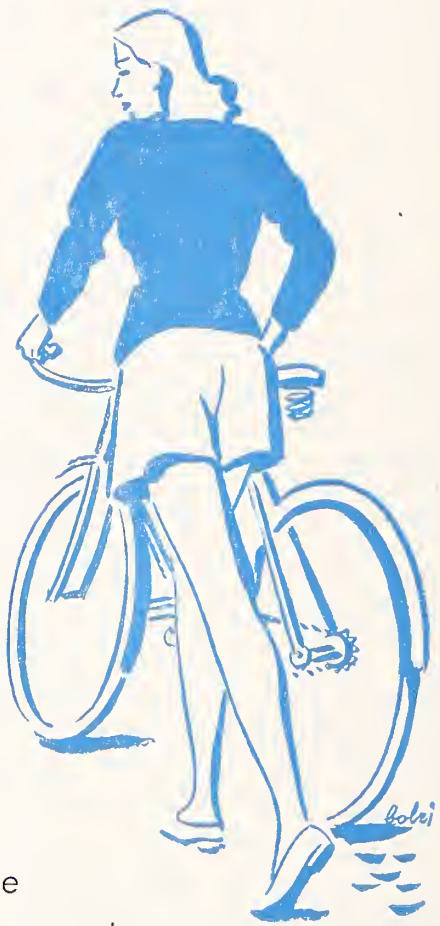
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The
CONNECTICUT STATE MEDICAL JOURNAL

Vol. XII JULY, 1948 No. 7

MODERN TREATMENT OF THYROTOXICOSIS

J. H. Means, M.D., *Boston*

The Author. *Jackson Professor of Clinical Medicine, Harvard University, Chief of the Medical Services, Massachusetts General Hospital*

The title was given me; I did not choose it, but I am very glad to talk on it. I might say that as I came down here from Boston this morning on the train I entertained myself by reading a paper by Alan Gregg, in which he decried to some degree our preoccupation nowadays with etiology. He didn't mean to minimize the importance of etiology, but he thought we were a little bit inclined to think of cases rather than patients. I think there is something in what he says, so perhaps it might be best to make this title read "The Treatment of the Patient with Thyrotoxicosis," and I may say that patients have thyrotoxicosis for different reasons. Thyrotoxicosis is not a disease; it is a reaction on the part of the body to stimulation and the stimuli may have different origins. I think it might be said to be somewhat analogous to fever perhaps, although there are more causes of fever than there are of thyrotoxicosis. Perhaps the most simple type of thyrotoxicosis is that which ensues when you take thyroid tablets. You can make yourself quite thyrotoxic by taking tablets, and we have run into a number of such cases, some of whom were taking it surreptitiously and, we use the term hyperthyroidism factitia, or thyrotoxicosis factitia. These individuals have interested us recently because we found a trick about making the diagnosis which depends upon laboratory tests. Their metabolic rates are elevated, of course. Their blood iodines are elevated because the hormone they ingest raises the hormone iodine in the blood; so from the points of view of those two tests they are no different from any other type of thyrotoxicosis, but if you give them a little radioactive iodine and find out how much the thyroid takes up, you will find it takes up very little. It doesn't need to take up any because it isn't doing any work. It doesn't have to do any work because the patient is ingesting thyroid from the outside. Here then is a rather amusing diagnostic stunt that one can use in trying to find out why a certain person seems to be rather mysteriously thyrotoxic without a goiter, and without any proper reason for it, and yet obviously is thyrotoxic. A little detective work and these laboratory stunts may show you that you have a psychotic individual who is taking thyroid in order to be ill.

Of course the commonest type of thyrotoxicosis is that which occurs as part of Graves' disease, and then there are other types that are due to hyperfunctioning thyroid tumors. For a good many years I questioned the existence of hyperfunctioning thyroid tumors. I never denied their existence, but I wasn't convinced that they did exist, but now I am convinced they do because it has been proved by means of radio-iodine uptake, and the use of what are called auto-radiograms. I will come to that a little later. I think before we get actually on the treatment of thyrotoxicosis, or the patient with thyrotoxicosis, I would like to say, with respect Graves' disease, a few words as to its nature and what we mean by that term. I would like first to remind you that thyrotoxicosis is by no means the whole of Graves' disease. There are other abnor-

A stenographic report of Dr. Means' extemporaneous remarks at the 22nd Connecticut Clinical Congress, New Haven, September 17, 1947

malities in Graves' disease which in some cases may be more important than the thyrotoxicosis. I would like to remind you that you can say there are several components to this syndrome. There is thyrotoxicosis, to be sure, in many of them. Then there is the ophthalmopathic component which in some of them is of more importance than the thyrotoxic component, which may even exist without any thyrotoxic component, and some patients have a profound myopathy or myasthenia which might be called a myopathic component, and one could identify other components of this rather complicated syndrome that is so complicated that we have to resort to an eponym to describe it, and call it Graves' disease. Now in the treatment of Graves' disease one would like very much to attack the fundamental etiologic cause or causes, but what are they? The trouble is we do not really know. We can identify perhaps certain precipitating causes or factors. We can recognize that, to some degree, hereditary factors may play a part in the families with many cases, and undoubtedly there is an hereditary component in the etiology of this condition. We can recognize also that certain things may predispose to it in the environment but actually beyond that we do not know very much about the precise etiology. I feel quite convinced that this syndrome is what you might call a disease of adaptation; that it is a kind of pathologic response that individuals with a certain constitutional pattern, and perhaps with a certain heredity, make when they encounter, in living, certain stresses that they can't take, but I admit that that is a rather diffuse, and general, and vague statement. It is about the best one can do, however. I have thought of it to some degree, after listening to that very entertaining person, Hans Selye, as a sort of alarm reaction gone wrong, or something of that kind. There are certain similarities between his so-called adaptation syndrome and Graves' disease. There are also some differences. With regard to the etiology, I would like to invite your attention to some things that have come up very recently, or at least within a year or two, that to me, are very fascinating, and bear on the etiology of this condition. What I refer to chiefly is the experience that has been had in the occupied countries of Europe. Some of you may have read about the experience in Denmark. Denmark was a country which was occupied and which suffered a great deal of deprivation, not so much in the sense of deprivation of food, but anxiety and tribulation of one sort or another. They had appa ently a perfectly well authenticated six-fold increa in the incidence of thyrotoxicosis of the Grave type in Denmark during the period of occupatio That is judging by the number of entries to ho pitals. You will find a paper by Professor Meule gracht of Copenhagen about it and I have talke with a number of Danes who have been over he since. They were all extremely interested in this an rather perplexed to explain it. The sequel was tha directly the country was liberated this incidenc went back in a matter of months apparently to normal prewar level. That was very interestin Then I talked with Dr. Jersild of Copenhagen abou it. He had observed it. I talked more recently wit Barfred of Odense, Denmark. He had observed and was very much interested in it too, but jus about ten days ago I got a letter from Barfred wh said that when he got back to Denmark he foun that the disease was again on the increase, quit definitely. We had some talks about what the reaso for this was. The Danes were terrified but no starved. In the other occupied countries there didn seem to be anything quite corresponding to thi situation. The Frenchmen and Belgians that I talke with had the impression that in their countrie thyrotoxicosis had probably been less frequent, an certainly had been milder, particularly as the degre of malnutrition progressed, and you got the impres sion that perhaps if one didn't ingest enough calorie one just couldn't get up a good thyrotoxicosis. On didn't have steam enough, so to speak. It seems therefore, that we may say this disease has a epidemiology. It isn't an infectious disease, yet i has an epidemiology. The only other moder epidemic, although there were some in the ancien literature that one can find, and the one that ha been best studied, was a long term epidemic whic took place in Olmstead County, Minnesota, and wa described very fully by the late Henry Plummer It worked up to a peak over a period of years an then subsided again.

If Graves' disease does have an epidemiology, the it may be concluded that there must be environ mental factors of some kind which play a role in it production. I mentioned this not because it bear directly on my subject but, because after all w prefer prophylaxis to curative treatment for an disease, and that includes Graves' disease along wit all the rest. Gregg has a great deal to say about th importance of the doctor's recognizing that hi

nction is to promote health, even before it is to re disease, and one would like to apply that to raves' disease. I do not know that we can, except a very general way by trying to promote good trition, if malnutrition has something to do with and I believe it has, also by trying to spare people om psychic traumata when that can be done; ually it can't be done. If we knew who was likely develop the syndrome then we might make a ecial effort to safeguard them against the factors at would precipitate it, but I don't know of any ay of predicting who is going to have Graves' sease except in the case of identical twins. We d one example here of a twin of eight who devel- ped Graves' disease. The only inciting factor that e could find in her case was that she lately had had n worms, and the treatment thereof was somewhat a psychic trauma to her. We thought it would be ry interesting to watch the other twin and see if e got Graves' disease. We didn't try to produce raves' disease by insulting her or anything of that rt, but just told her mother to treat her gently. ven so the other twin developed Graves' disease yo years later.

So much for the etiologic approach to this con- tion. We can't do very much as I am sure I have ade evident, along an etiologic approach, either in ophylaxis or treatment. Therefore we are forced, is so often the case in the practice of our profes- on, to proceed with nonspecific therapy. Some of e measures I am going to speak of in a moment are irly specific in a sense, but they are nonspecific in at they do not remove the fundamental etiologi- l agents that produce the disease. I would also ke to indicate that in treating Graves' disease by mptomatic procedures, one has got to vary the eatment from patient to patient because of differ- ce in the indications. In one patient the thyro- xicosis will be severe and that will be the thing at will demand treatment. That is what you want e to talk about, the treatment of the thyrotoxicosis, t in another case there may be little or no thyro- xicosis and the eyes may be the main indication r therapy, so that one has got to individualize, d cannot lay down any general rules for treating l cases of Graves' disease. You have got to make e treatment fit the particular picture that the ven patient presents. If you insist on a generaliza- on I would say treat that part of the disturbance hich is likely to be doing the most injury, and by the same token, refrain from doing any injury yourself.

I know that what you really want from me is my opinion about these new-fangled methods of treating thyrotoxicosis, but we might first off, before we get to the thyrotoxicosis of Graves' disease which in this part of the country, at least, is the most important part of this general subject, dispose of the other kinds. I have mentioned thyrotoxicosis factitia. The thing to do there is to make a diagnosis and persuade the patient to stop taking thyroid, of course. Now with respect to hyperfunctioning tumors—what about them? We believe that they should be taken out. We still believe that they should be taken out—I might put it that way. Sometimes it is very difficult to know just what kind of a toxic goiter you are dealing with. If you have eye signs and if the goiter is diffuse, you are certainly dealing with Graves' disease. On the other hand, if you have no eye signs and a lumpy or nodular goiter, it may be of the Graves' type, because sometimes eye signs are lacking in Graves' disease and the goiter may get irregular and feel somewhat nodular, but it may be an adenomatous type of thing, multiple thyroid adenomata, fetal or otherwise. If there is only one lump, no eye signs, and thyrotoxicosis, nowadays we are inclined to believe that it is a hyperfunctioning adenoma. However you can't really make a final decision about that unless you resort to the use of these modern procedures, chiefly the uptake of radio iodine, letting a slice of thyroid take a photograph of itself after it has taken up radioactive iodine. You will find that these tumors of the thyroid run all the way from those in which the tumor is the only thing that will take up iodine, and is therefore producing all the hormone that is being produced by that thyroid, and the rest of the gland in consequence is atrophic, to those in which the tumor will take up no iodine and the rest of the gland seems to be responsible for the hyperfunction. In the latter cases the picture is probably more nearly related to Graves' disease and the tumor incidental as far as thyrotoxicosis goes. You may find intermediate types where both tumor and the rest of the gland take up some iodine. We are very eager to find out about such things, and of course our diagnostic or scientific curiosity makes us very eager to take out these thyroids so we can study them, but we also have convinced ourselves, perhaps—I hope

not wishfully, that that is the best thing for the patient also. One does not like to leave any kind of tumor in the body if one can conveniently, without risk, remove them, and there are malignant tumors of the thyroid. The malignant ones do not usually hyperfunctionate. I used to say rather dogmatically that if there was hyperthyroidism you could be sure there wasn't malignancy, but now in my old age I know that isn't always true, so that one cannot make such a positive statement. We have found malignant lesions in hyperfunctioning thyroids, so that we believe that these patients, unless there is some direct contraindication, should usually come to operation. The preparation for operation of these cases, if they are toxic, is not materially different from that of Graves' disease so I will just let it go at that and get on now to the treatment of Graves' disease, particularly its thyrotoxicosis.

I think that it would be wholesome at this point to review the various possible parts in the mechanism involved at which one might aim one's therapeutic procedure. You will recall that the thyroid is stimulated by the thyrotropic hormone of the anterior pituitary, and that the pituitary itself receives impacts via the central nervous system, probably chiefly routed through the hypothalamus. It would be logical to aim a therapeutic attack in a patient with Graves' disease and thyrotoxicosis at any of the levels from the brain to the end organ of the thyroid hormone. The highest level would be an attack directed at the nervous system. That may be of vast importance in prophylaxis. I have rather indicated that already, but after the syndrome has been precipitated and the morbid mechanism is established, I think that an approach on this highest level, which would be some form of psychotherapy, is absolutely worthless and contraindicated. We did have a psychiatrist once that got loose in the thyroid clinic and tried to find out about the possibilities of psychotherapy in thyrotoxicosis. An aggravation of the picture was about all that resulted and a separation of the psychiatrist from the clinic. I am not trying to laugh at the psychiatrist. It is just that this is not the proper place to make use of his sometimes extraordinarily valuable services. Now then going down a level, to that of the anterior pituitary. Could we direct a therapeutic attack against that? We could, of course, but how worthwhile is it, or how safe is it to do that? You can't ablate the pituitary in the human. You could ablate it, but then you would end up with Simmonds' disease if it was done surgically and if the patie survived the procedure. If it was done with irrad tion to the point of producing a marked hyp function of the thyrotropic activity of the pituita you probably would also get a hypofunction of the other many tropic functions of the pituitar and all you would have accomplished, it seems me, would be to have converted your patient wl had a case of Graves' disease into one with a case Simmonds' disease. You wouldn't want to do th because Simmonds' is even more undesirable tha the Graves' disease. I would think that irradiatic of the pituitary as a treatment for Graves' disea could also be ruled out as not of any great value, an probably quite hazardous. The only place where can see that it might be useful is in the case wit malignant exophthalmos and not much hype thyroidism, but even there I would be rather afrai of the other hypofunctions that I might bring abou Now then another thing that can be done to sup press the pituitary which would be much le hazardous, perhaps also not very efficacious, woul be to give thyroid. I used to think the suggestio that one give thyroid to a thyrotoxic patient wa nonsensical but perhaps it isn't nonsensical. W have given it to a number of patients, and othe have done so. Elmer Sevringhaus told me he ha given it to several patients, and his experience an our experience apparently check, and that is tha you can give these people with thyrotoxicosis quit a lot of thyroid without aggravating their thyro toxicosis. At a high level of metabolism they ca tolerate a great deal more thyroid than a perso with a normal level, just as a person with a norma level can tolerate more than the person with com plete myxedema, but whether it does any good o not in the way of suppressing the pituitary is un certain. Thyroid does suppress the pituitary wit respect to thyrotropic hormone output. That ha been proven in the laboratory, but whether thi can be taken advantage of therapeutically is anothe matter. We have been trying some experiment along this line. It occurred to me, having heard my colleague Albright talk about his great desire t find a non androgenic androgen so that he might give a great lot without getting an androgenic effect but get the effect on protein metabolism, that I might find a non calorigenic thyroxin, so to speak. Dextrorotatory thyroxin has a very low calorigenic action and would be just the thing to use. Perhaps you could deceive the pituitary with it—then again

rhaps you couldn't. We don't know because we n't get any dextrorotatory thyroxin, not in suffi- ent quantity. I have talked with all the people ho might give it to us and it is very difficult to cure. My colleague Lerman is experimenting with me tetrabromothyronine which is just like thy- xin only with bromines in it instead of iodine. If gives 15 times up to 20 times the dose of tetra- om as he would tetraiodo or ordinary thyroxin, is material has just exactly the same action as yroxin. It will cure myxedema, or relieve it com- etely. Now we want to give it to some patients in ge doses, and we are starting observations, but e haven't really gotten where any conclusions can drawn as yet. One other thing on the pituitary el that can be mentioned is the use of antisera. rman also has tried to produce antisera. It might possible since thyrotropic hormone is a protein— get an antibody to it which could be given erapeutically, but I do not think anything has t emerged that has any practical application in at panel either.

Now going down a step to the thyroid itself. hat can we do about the morbid hookup at that el? You might use the expression "vicious circle." u can interrupt the vicious circle at various aces in its circumference. We have come now to e thyroid part of the circumference of this vicious cle. You can ablate the thyroid, certainly. You n take it out and thereby do a great deal of good. at is the time honored method of treating thyro- icosis, to do a subtotal or even a total thyroid- tomy, and that unquestionably relieves thyrotoxi- sis. If you do not take out the whole thyroid the ease may recur of course, but as a matter of fact recurs in a smaller proportion of cases than it oretically ought to. I have always felt that the ults of subtotal thyroidectomy for Graves' ease were better, by and large, than they theo- ically should be. Theoretically you would ex- t them all to regenerate thyroid and have the ease over again. The fact is that most of them not. I do not know why, but I am interested in e fact. Another thing you can do to suppress the yroid, of course, is to irradiate it and knock its ls out by irradiation, and that is essentially doing same thing as thyroidectomizing. You cannot ve thyrotoxicosis if you remove the factor that kes thyroid hormone. You can knock the thyroid t with irradiation. We used to do it, of course, l many of you probably did, with x-ray, and the results were fair in many cases. Now we can do it more conveniently and more effectively and at least with less risk to the overlying tissues, because they are not traversed, by administering radioactive iodine which now can be obtained from Oak Ridge, Tennessee. If you let the thyroid cells take radio iodine up, you have your source of irradiation right inside the cells you wish to irradiate. It works very well. I shall come back to this matter when I try to give you a relative evaluation of these various methods of therapy. At the moment I am trying to indicate as a first screening, the approaches at the different levels and whether they offer something or do not offer something. Certainly treatment with radioactive iodine offers a great deal and is a very interesting method of therapy.

Then of course there is the great matter of anti- thyroid drugs that has come upon us in the last few years, drugs which interfere with or make impos- sible the production of physiologically-active hor- mone by the thyroid. They thwart the gland in its function, and they certainly are very useful thera- peutically. I will try to evaluate them as they relate to other methods, in a few minutes. Then of course there is iodine itself which can be given in the thyrotoxicosis of Graves' disease and ever since 1923 when Henry S. Plummer introduced it, or rather reintroduced it, it has been used very widely, and is one of the important tools in our therapeutic kit bag for treating this malady. Iodine does not always completely correct the thyrotoxicosis, nor does it in any sense, I am sure, cure the disease, but it may relieve thyrotoxicosis for considerable periods of time and indeed I think it will relieve it in part as long as you exhibit the drug. How does it work? There have been various theories of how it works. Some recent work of my colleague Rawson suggests that it may work at the level of the thyroid cell by antagonizing, at that point, the action of the thyrotropic hormone.

Although the thyroid may not be by any means primarily at fault in Graves' disease, the best practi- cal results at the moment are obtained by aiming your onslaught at it and trying to suppress its hyper- functioning in the thyrotoxic types. Now there are lower levels from which a therapeutic attack might be launched. One might perhaps get an antibody to the thyroid hormone. That has been tried. Indeed it has been tried not only recently but many years ago. I do not think anything has emerged that is of practical value, but theoretically, at least this

ought to be a possible method of treating thyrotoxicosis. Theoretically, if you could in some way suppress the sensitivity of end organs to thyroid hormone, and that presumably would be every cell in the body, you might have another method of attack, but I have no idea how that could be done. Insensity of end organs occurs spontaneously sometimes, as in certain cases of parathyroid disease where the end organs apparently are insensitive to the parathyroid hormone, and you have a huge amount of parathyroid hormone manufactured without any clinical hyperparathyroidism. Albright has been very much interested in this. Whether something comparable might be found in the case of thyroid, I don't know. Some of the non myxedematous low rate cases may fall in that category. One other possibility would be to find some agent, other than an antibody, which might peripherally neutralize the action of thyroid hormone.

One other thing might be mentioned, and I do not know what level to mention it at because I do not know how it is routed, whether directly or through the pituitary, and that is adrenocortical extract. The hormones of the thyroid and at least some of the cortical hormones apparently are antagonistic to one another. In patients who develop a thyrotoxic crisis nowadays we use large doses of cortical extract and we think it does good. The only trouble is that the cases are so rare and so impossible to control, that one really hasn't got a very good basis for judgment as to how efficacious the therapy is, but I believe that it is efficacious and I certainly would use it. Now whether it directly antagonizes the thyroid, or whether it is routed through the pituitary, I cannot tell you; I suspect the latter.

Well now we are getting down to earth graduarlly and what you want now is for me to tell you the relative merits of iodine, thioureas, thyroidectomy and irradiation in the thyrotoxicosis of Graves' disease. There are various ways you can use these agents. You can use iodine all by itself. We used to do that, and there were some mild cases which were prefectly satisfactorily treated by that method. The iodine corrected their symptoms and they felt all right, and if you kept treatment up long enough the disease apparently came to a natural end, and that was all that was required. The trouble is how to pick suitable cases in advance.

Of the antithyroid drugs I think the best at present is propylthiouracil. It may not be quite as potent in some cases as thiourea but it is probably less toxic, and I think is the drug of choice, althou the British and Australians have had very good lu with methyl. Thiouracil itself is very satisfacto really, but I think propyl is a shade better. Th drugs may be used as the sole method of treatme and I have no doubt that some patients, if the tre ment has been carried out long enough, have covered from Graves' disease, or gone into a pern nent remission. They are not very numerous, ho ever. Thiourea may also be used as the late I Winkler used it here, in conjunction with iodi I have not had any very great experience about t combined use of iodine and thiourea, or thioura combined with iodine as a sole method of therap but it is possible that the effects of the two are some degree additive.

Irradiation by means of radio-iodine in our han has been very satisfactory, and I think would be f and away the method of choice, except for the po sibility, years later, of some untoward resul People are afraid that it may in later years produ malignant changes. I haven't any idea what th likelihood of that may be and I do not know ho one can find out except by the brutal method clinical trial. I have talked with experts who kno a great deal about the effects of irradiation, and g divergent anwers. If it was not for the possibility late carcinogenesis I think radio-iodine therap would be close to perfect. It is easy to take. Yo just take a glass of water, usually only once, wi a little KI in it, part of which is radio-active, ar that is all that needs to be done. We are using now only in patients over forty. Because of th malignancy possibility we prefer not to use it younger people.

However, as a matter of fact, we being rath conservative, are still, I must confess, using thyroid ectomy to a considerable degree. I can say this, th the advent of antithyroid drugs has been a gre advance in the regime for preparing patients fo operation. It is possible now, by means of ant thyroid drug to give the surgeon a euthyroi patient, a patient who is not thyrotoxic at all. Th reduces, is bound to reduce, operative mortality. in addition you give iodine you can also involut the thyroid and thus give the surgeon a patient th is euthyroid and whose thyroid gland is involuted ideal for him to operate on as far as local ease the procedure is concerned. In our experience wit such a regime the results have been excellent. Th number of postoperative complications, not suc

nes as are due to clumsiness on the part of the rgeon, but ones that are due to shock of the rocedure, have been greatly reduced. It is possible ter the thyroidectomy to omit both these drugs d indeed usually to give no more therapy, but mply to watch the patient and see him or her cover a normal state of health; so that if you want avoid in younger people the use of radio-iodine cause of the possibility of late carcinoma, I would ill prefer to use this surgical program that I have st outlined than subject them to many months' eatment with a toxic drug which after all may end up with an intolerance of some sort or with only a brief freedom, a temporary remission of the disease and then a return of it. I would rather get them well as you can usually do with a surgical procedure than stumble along with prolonged drug therapy. I am perfectly prepared to change my mind, but that is the way I feel at the moment. I think one should be open-minded about these things and I would predict that the ultimate treatment of this disease will turn out not to be any of the things I have mentioned, but something quite different.

ARLY TREATMENT OF MENTALLY ILL IN REHABILITATION AS VIEWED BY THE GENERAL PHYSICIAN

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Vocational rehabilitation came into existence a little over twenty-five years ago as a natural onsequence of the presence of many thousands of ndicapped citizens. These unfortunates because f their disabilities could not engage in any profitble work that would enable them to earn a living. hey whiled their time away in idleness depending pon the goodness of their relatives and friends and f the little their local communities saw fit to supply em with, just enough to maintain a mere existence.

As our country grew in the number of its citizens, e handicapped also increased in number. The two Vorld Wars added a tremendous number of aimed to the already existing millions of handiapped. Vocational rehabilitation by now became an tegral part of the State and Federal Government, ese two agencies entering actively into the field f rehabilitation. To meet the demands of the many ndicapped for an independent economic life vocaonal rehabilitation had to broaden the scope of its ctivities, so that today its purpose is "to preserve r restore the ability of our people to work for pay. ll men and women of working age with substantial job handicaps in the form of physical or mental impairments are eligible."[1]

In this paper the writer concerns himself with one phase of rehabilitation only, namely—the mentally ill. It is for their rehabilitation that he pleads. He is eager to find some short cut to restore the handicapped back to normalcy. He seeks early methods whereby the applicant may be restored to his previous plane before his mental state becomes disoriented and fixed, before it will be necessary to confine the applicant to an institution where he will finally and perhaps too late get his treatment. The writer's aim is to accomplish rehabilitation with the minimum loss of time to the handicapped individual, with the most economic saving of money to the state and federal government, and with as long lasting workable period for the handicapped as is possible.

According to Dr. C. Charles Burlingame of Hartford, shock therapy was known as far back as 1798 when Weikard used it by employing camphor as the agent inducing convulsive seizures. However, it was not until Sakol, von Medina, Carletti and Bini that shock therapy was established as a recognized method of treatment for certain mental disorders.

In 1928 at the Potzl Clinic in Vienna Manfred Sakol accidentally discovered a new treatment.

While treating morphine addicts with insulin he noticed that deep hypoglycemic reactions were followed by marked improvement in the mental condition of the same patients. Sakol's method was followed by Stanislau von Medina, who in 1935 reported at the Royal Hungarian Hospital of Budapest the treatment of schizophrenia cases by the intravenous administration of metrazol in doses large enough to precipitate convulsions similar to those in grand mal. In 1938 U. Cerletti and L. Bini announced the use of intentionally produced electric convulsions in the treatment of certain groups of mental disorders.

Until the introduction of these new methods the treatment of the mentally ill was a slow process, and was mainly in the form of supervision. Even with the best existing methods of that time social adjustment and improvements were the exception, and the so-called "cure" could not be hoped for before a year or two, provided the patient was confined to an institution. Relapses were common, and a second admission to an institution usually meant a permanent residence there. Much valuable time was consumed without accomplishing any appreciable result. Institutions were crowded. Many thousands of valuable work hours were lost, and many otherwise useful citizens were kept from pursuing a normal, profitable and happy life.

Today shock therapy constitutes an important part of the armamentarium of psychiatric therapy. Here is what Dr. Joseph L. Fetterman[2] states: "Electro-coma therapy has clearly established its remarkable usefulness in the space of some seven years since its introduction in psychiatry. . . . A vast experience by an ever widening circle of psychiatrists has demonstrated that electro-coma therapy is the present method of choice in illnesses characterized by severe depression." In 1945 Dr. Robert W. Staley[3] made this interesting statement: "Many workers, who had an aversion to the administration of electric shock therapy prior to experience with it, upon giving it an adequate trial and observation have become enthusiastic advocates. Others, who gave it an initial trial and lost interest because of the fractures, after adapting a better technique with practical elimination of fractures, have returned to this form of therapy stronger advocates than ever. . . . Electric shock therapy has come into most universal usage today because it not only reaches the vast majority of shock candidates but it is the most simplified form of therapy, is associated with the least amount of anxiety on the part of the patien maintains the least serious complications, and more applicable to ambulatory patients. . . . I my opinion the value of shock therapy cannot b denied. . . . One who has not observed i functioning and results cannot have a proper appr ciation of its benefits. It is the most efficacio weapon that we have to date in combating th psychogenic group of psychoses. It is of distinc advantage in the treatment of certain of psycho neuroses of long standing that have not responde to adequate psychotherapy. The patient is man times made more amenable to psychotherapy."

In a paper written by Dr. G. J. Gordon and Dr M. B. Zimbler[4] we read: "Electro-shock therapy ha become known to be the most harmless and the mos widely accepted form of shock therapy in the psy chiatric field. It combines comparative safety i applied to a carefully selected material, with easy applicability and a saving of time and energy to the supervising personnel. Violent outbursts can be more readily held in abeyance while the actual risks to life and property are reduced to a minimum." Electro-shock therapy does not as yet represent the ultimate panacea in the treatment of mental disorders and does not always bring desirable and hoped for results. However, better knowledge of the entire field of electro-shock therapy is on the way, more improvements in the mode of its administration have been devised. Many psychiatrists who employ this method of treatment are convinced that a more protracted course with from twelve to twenty treatments should be the minimum. Under such a procedure remissions and cures are lasting; relapses are fewer, and when they recur are amenable to treatment again. The time needed for the treatment is considerably shortened; there is a saving in expense, and the patients are able to take care of themselves and can engage in work that will enable them to support themselves and their families.

I believe, therefore, that no attempt in curing or improving the condition of the mentally ill patients should be considered complete until electro-shock therapy has been given a thorough trial.

Since the new method of treatment has been inaugurated hundreds of papers have been written glorifying its merits. It was only natural that the bulk of the papers expressed at first overwhelming enthusiasm, over-optimism and claimed brilliant results. As time went on and more and more patients were treated with electro-shock therapy, as more

en took on this approach of treating the mentally
as more details became known, a saner and more
ber aspect began to take place. Fractures occurred,
results were reported, there were cases of tem-
prary loss of memory. More and more critical
ports began to appear in the medical journals.
ore knowledge and better explanations were de-
nded by many men who at this time began to
ubt the value of the treatment, even saw harmful
fects, condemned it and abandoned its use.

Many of the men using electro-shock therapy
ve us their version as to the mode of action of
ctro-shock therapy.

Dr. Thomas A. C. Rennie[5] makes the following
tement: "Insulin therapy permitted a marked
gree of relaxation, released ability to discuss pre-
cupations easily, and provided the therapeutist
ith a real opportunity to get closer to the patient
d his basic needs. It permitted catharsis in certain
ained fear states. Even when the patient never
scussed fundamental dynamic material, the insulin
ten released inner tension and alleviated anxiety
d fear." Dr. Nolan D. C. Lewis[6] writes: "With
e rather rapid relief from emotional tension expe-
nced by the patient under shock therapy, his
mpensatory forces are freed more quickly and
n work more rapidly towards a reconstruction of
e defense and adjustments than is possible by
eans of a slower 'spontaneous' process."

Out of the maze of the hundreds of papers one
n discern some definite statements upon which all
orkers in the field of psychiatry agree upon. By
is time it has been definitely established that some
ases of mental instability may be approached with
uch more ease than others; that prolonged periods
remission and oftentimes complete cure may be
ticipated when using the shock therapy method
r a longer time with a greater number of treat-
ents than before. It has been definitely established,
o, that shock therapy shortens patient's stay in an
stitution, thus saving valuable and costly time, and
so releasing pent up "potential energy" that be-
mes active and useful. In one of the many papers
ritten by Dr. A. E. Bennett[7] he states: "Insulin
eatment offered a saving of approximately 286,695
ys of hospital care which is a saving of approxi-
ately $80,294 in cost." This was accomplished in
period from January 1937 to June 30, 1942. One
ust remember, too, that there are many hospitals
this country caring for the mentally ill, and that
e aggregate saving in time and money in all these
institutions is very great. Men doing work in the field of electro-shock therapy are of the opinion that all varieties of shock therapy with their modifications and combinations are a fairly safe procedure when administered by men who are properly trained. Dr. Jacob Norman and Dr. John Shea[8] state: "During the three years during which we have employed electric shock therapy, approximately 4,000 treatments have been administered and complications have been negligible. There have been no fatalities and no fractures of the spine or other bones." According to Dr. D. C. Lewis[9] "Electrically induced convulsion therapy appears to be safe and convenient a method of treatment of mental disorders." According to Dr. G. J. Gordon and Dr. M. B. Zimber:[10] "Electro-shock therapy has come to be known as the most harmless and the most widely accepted form of shock therapy in psychiatric field. It combines comparative safety if applied to a carefully selected material." The treatment may be given in "outpatient clinics" when the cases are properly selected, and the treatment is manned and conducted by a properly trained personnel. Here is what Dr. J. L. Fetterman[2] says about the outpatient clinics: "It was found that a considerable number of patients could be satisfactorily treated in an ambulatory manner. During the past few years, because of bed shortage, it was impossible to hospitalize all those who needed electro-convulsive therapy, and thus many physicians resorted to ambulatory methods. It was found that results were good, if not better, when patients were permitted to remain at home . . . I have been able to treat 50 per cent of patients who required such therapy in an ambulatory fashion. . . . It is remarkable that patients who receive treatment in the morning may do housework, play golf, and even continue lucrative employment the same afternoon or on the day between treatments."

The sooner the psychiatrist institutes the treatment the better is his chance to get good results. Patients whose ailment is of six months' duration have the best chance for recovery. Colonel B. Simon[9] believes that instituting early treatment is of paramount importance if good results are to be expected. Dr. J. Norman and Dr. J. T. Shea[8] state that experience convinced them that the great factor in the prognosis of shock therapy in schizophrenia is good if the treatment is instituted early in the disease, if the cases are of sudden onset and do not show marked remission. Dr. M. C. Peters and Dr.

Thomas R. Turner[10] are of the belief that electro-shock therapy gives better results when given early. Of their patients who were treated within six months after the onset of the psychosis 56.7 per cent became socially adjusted; where they started treatment between six to twelve months after the development of the psychosis the percentage of adjustments was only 36.6, whereas it dropped to 13.9 per cent where the psychosis was present for more than one year.

Dr. J. H. Taylor[11] completed treatment in 1,605 acute cases. The principal psychoses he treated were schizophrenias, manic depressives, involutional psychoses. Dr. R. W. Staley[3] treated 3,276 patients since September 1944. Of these 2,056 patients were treated with electro-shock therapy only. Schizophreniacs, manic depressive psychoses, psychopathic personalities, involutional melancholias, senile depressions and the psychoneurotics including hysterias and obsessional compulsive states, neurasthenias, reactive depressions and anxiety states all constituted the various groups treated.

In the daily routine work of examining and evaluating prospective wage earners one oftentimes meets so called "psychiatric problem" applicants. They appear to be perfectly normal, ordinary fellows, perhaps a bit eccentric, odd. However, after spending a little time with them and listening to their personal histories as related by themselves, one comes to the conclusion that he deals with a definite "psychiatric" element. These applicants belong to that group of clients, who, unless taken care of immediately, will develop a state of mental confusion, will exhibit a definite affective psychosis of some sort and will eventually land into an institution for mentally ill.

From January 1945 to December 31, 1946 1,160 applicants came to my office either for physical examination or for evaluation for placement. Of these 152 clients 7.5 per cent belonged to the inadequate personality group; 13 per cent belonged to the psychoneurosis group, while 10.5 per cent were of the schizophrenia group. This is rather an impressive figure. These applicants seek our aid and surely deserve the chance for rehabilitation.

All human beings are a combination of psychosomatic components which cannot be split asunder. It is about time that the medical world, with special emphasis on the industrial physician, realizes this fact. Their understanding of the word "disease" must undergo a change, must be broadened in its meaning and must be extended to a far more libe horizon. For once the medical profession must a cept the axiom that there is no physical side a no mental side per se to the question of disease. Tl division into "organic" and "functional" is arbitra only for want of a better understanding and e planation and a clearer comprehension of the hum being. All patients must be examined "stereoscopi ally" from all angles. To make a proper and ju appraisal of an applicant when he presents himse to the examining physician, this fact must never l overlooked. The human being is the only atom th cannot be split into its component parts. Psyche ar soma are always interwoven, and no correct dia nosis is possible if this interlocking is not taken in consideration.

The applicants when they present themselves the office of Vocational Rehabilitation, are still en ployable, although one is never certain just ho long this employability will last, or how soon th psychopathic element will explode and will sen the applicant to an institution. These applican are willing to do anything and are willing to unde go anything as long as they will eventually be er abled to earn an honest day's wage. I am aware c the fact that in the electro-shock therapy metho we have not as yet reached our final goal of per fection in the treatment of the mentally ill. Ye we have advanced a great deal. True, much is t be explored, much to be learned, much to be im proved. But then what in life has reached its millen ium? We use sodium dilantin in epilepsy knowin well that this is not the solution, that it does no cure the victim of his seizures. Should we, there fore, discontinue its use? The removal of a cancer ous breast does not necessarily cure the patient o her cancer. The surgeon is well aware that in th majority of cases the operation is only a palliativ measure. Should he, therefore, refuse to operate Radium and deep therapy do not always, as w well know, bring the hoped for results. Should th radiologist, therefore, hang out a sign: "Offic closed indefinitely?" Scientists have discovere atomic energy, and with its discovery came a new world filled with thousands of possibilities an wonderful potentialities. It has a bright future fo the betterment of the world. By the same token it destructive power has been clearly demonstrate during the Second World War. Should the scien tists abandon their further research because of thi destructive power? Life is fluid. It never for a moment stands still. It forever seeks improvement

Igropes for new discoveries, finds them, tries them, iproves them or casts them away if they prove wnting. And so it is with electro-shock therapy. I o not plead for haphazardous, indiscriminate use o it. I fully agree with Impastato and Almasi[12] who a ong others have insisted that the patients should b studied carefully neurologically and biochemic- al in addition to having electrocardiographic and e ephalographic evaluations in connection with th treatment.

akol, von Medina, Cerletti and Bini have given u comparatively safe, inexpensive and uncompli- c ed methods of treatment of our mentally ill a plicants. The medical profession possesses by now s ficient evidence in the form of clinical data, la oratory findings to be able to judge with fair a curacy as to the time and advisability of the a ministration of electro-shock therapy, as well as th selection of the proper group of patients who are g ng to benefit by it.

plead for these unfortunate applicants that w enever a diagnosis is made that they should i nediately be directed to the proper places where th electro-shock treatment may be administered w hout delay by properly trained staffs, under p per conditions and under proper supervision. If o y a small percentage of all the applicants will th s be rehabilitated and sent back into society as w rthy members who are again able to support th mselves and their families; if many more can be m le more comfortable so that they spend the rest o their lives at home properly adjusted and able t do some work, I believe that the object of re- h ilitation will be well accomplished and well w rth while. If men doing electro-shock therapy el m that an early start is a good beginning; if th y claim that by widening the scope of their activities beyond the walls of institutions they will reach a greater number of patients, why not start treatment on these prospective applicants immediately after their condition has been diagnosed? The treatment as we know it today is safe when properly administered; the applicant has little to lose and much to gain. Why then the procrastination? Why lose time?

BIBLIOGRAPHY

1. Standards and Procedures of the Connecticut Division of Rehabilitation State Department of Education.

2. Fetterman, J. L.: Advances in Electro-Coma Therapy of Psychoses. Ohio State Med. J. 42:1133-1136, 1946.

3. Staley, R. W.: Present Status of Shock Therapy in the Treatment of Nervous Disease. Penn. Med. J., 48: 573-576, 1945.

4. Gordon, G. J. and M. B. Zimbler, M. B.: Delaware Med. J., 18:125-131, 1936.

5. Thomas, A. C., Rennie, M. D.: Use of Insulin as Sedative Therapy Control of Basic Anxiety and the Psychoses. Arch. Neur. and Psych. 50:697-705, 1943.

6. Nolan, D. C., Lewis, M. D.: The present Status of Shock Therapy in Mental Disorders. Bull. of the N. Y. Acad. of Med. 19:227-244, 1943.

7. Bennett, A. E.: An Evaluation of the "Shock" Therapies. The Psych. Quarterly, 19:465-477, 1945.

8. Norman, J., and Shea, J. T.: Three years' experience with Electric Convulsive Therapy. N. E. J. Med., 234: 857-859, 1945.

9. Simon, B.: The Treatment of the Neuropsychiatric Patient in Army Hospital. Med. Clin. N. A., March, 1946.

10. Peters, M. C., and Turner, T. R.: Electric Convulsive Therapy of Mental Diseases. Med. Clin. N. A., 27: 1019-1023, 1943.

11. Taylor, J.: Shock Therapy. Med. Sci. N. J. 42:300-304. 1945.

12. Impastato, D. J., and Almasi, R.: The Electrofit in the Treatment of Mental Disorders. J. Mental and Nervous Dis., 96:395, 1942.

GLAUCOMA AS POST OPERATIVE COMPLICATION OF HYSTERECTOMY OOPHORECTOMY, ENTERECTOMY AND ENTEROENTEROSTOMY

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THE patient was a sixty-one year old white female, weighing eighty-seven pounds. Her chief complaint was a swelling of the lower abdomen—duration of several years. On examination the abdomen was seen to be somewhat tense and moderately distended by a suprapubic mass. This mass was slightly movable and consisted of a right and left sided lobule about 6 to 8 cm. in diameter and a central, firm, irregular lobulated mass extending about to the umbilicus.

At operation the main tumor mass was found to be a solid tumor of the ovary extending to the costal margin and with an area of degeneration in its lower pole which contained chocolate colored fluid. This tumor when removed was found to weigh seven and three-quarters pounds, and with the lost fluid probably weighed over eight pounds. This mass originated in the right ovary. The left ovary was small and apparently normal. There were a number of small fibroids in the uterine wall but the uterus was not markedly enlarged. The ovarian mass had become firmly adherent to the lower leaf of the mesentery of the ileum, so firmly that it could not be separated without damage to the mesenteric vessels. There were a few other adhesions between the omentum and the mass. The usual hysterectomy was performed, the only difficulty occurring when an attempt was made to free the main tumor from its adhesions to the mesentery. This was found to be impossible, so the tumor was removed with about ten inches of ileum. An end to end enteroenterostomy was done. The abdominal wall was closed in layers without drainage.

The pathological diagnosis was: Right ovary: papillary adenocarcinoma; uterus: senile atrophy and multiple fibromyomata; small intestine: adhesions.

Postoperatively the patient was given 350 cc of whole blood and a Levine tube was passed with suction every hour. She was given small amounts of prostigmine and occasional infusion of Amigen 5 per cent with glucose. On the third postoperative a Miller Abbott tube was passed into the stoma This tube was gradually advanced during the r few days.

On the fifth postoperative day the patient c plained of neuralgia-like pain over the right which seemed to continue in spite of warm c presses and sedatives. On the sixth postoperative the tension in the right eye was found to be 5 by Schiotz tonometer. The eye was definitely h to fingertip pressure and showed deep scleral inj tion. The cornea appeared moderately hazy, that prevented a good view of the fundus. T impression was that there was also an immat cataract in this eye but this could be determi later under cycloplegia. A diagnosis of glauco acute, right eye, duration about thirty-six hou was made. It was suggested that eserine 2 per ce one drop every minute for five minutes every ho be used in the right eye. Also, that 100 cc of 50 cent glucose in saline be given intravenously a repeated in six to eight hours if necessary. If th measures would not reduce the tension a paracente of anterior chamber, as palliative, or iridectomy, curative, were suggested.

This suggested treatment was begun at about 1: P. M. At 4:15 P. M. the tension in the right eye w 25, the left eye 19, Schiotz. Eserine 2 per cent w used every other hour, one drop a minute for fi minutes from then until 9:00 P. M. At 9:30 P. M. t tension in the right eye was 20, the left eye Schiotz. Eserine 2 per cent was reduced to one dr every four hours thereafter. No further intraveno glucose in saline was given.

The next morning the eye was free of pain a the tension was found to be 19 in each eye, Schio One drop of eserine 2 per cent was used every fo hours during the day.

The following morning the tension in the rig eye was 19 and the left eye was 60, Schiotz. T unexpected tension in the left eye was felt to be

*Dr. McCreery died January 31, 1948

igting up of an incipient glaucomatous condition hough equalizing the pressure in the right eye. The e eye was treated just as the right eye had been r ted, with eserine 2 per cent, one drop every n ute for five minutes every hour. At 5:30 P. M. the e ion in the right eye was 15, left eye 19, Schiotz. E rine 1 per cent was now used, one drop in each y every four hours.

The next morning the tension was right eye 19, e eye 19, Schiotz. The following day the tension w found to be right eye 15, left eye 15, Schiotz. E rine 1 per cent was then instilled twice daily in ea eye.

t about this time it was noticed that the patient w very hoarse and a laryngeal examination showed th right cord to be fixed almost in the mid-line po tion. The left cord was freely movable. The di nosis was abduction paralysis of the right vocal cd—cause unknown. The patient also began to co plain of headache, especially over the left eye. Ts headache was fairly well controlled with as rin.

The next day the tension was right eye 19, left ey 15, Schiotz. Eserine 1 per cent was being used tv ce daily in each eye. At 9:00 P. M. the tension in th right eye was 35, in the left eye 15, Schiotz. We us d eserine 1 per cent, one drop every four hours in he right eye during the night and eserine 1 per ce t, 1 drop at 8:00 A. M. and 8:00 P. M. in the left ey. The next morning, at 9:00 A. M., the tension in th right eye was 19 and in the left eye 15, Schiotz. A this time it was noted that the right pupil had ne er become fully miotic with eserine. There were ve y likely posterior synechia as a result of old ir ocyclitis. It is thought that the right will very lik ly require care, even after her present hospitaliz ion is completed.

The use of eserine controlled the tension in both eys very nicely and she was allowed full activity, b ng discharged on the thirteenth postoperative d .

The patient was seen regularly in the office during th next few weeks. She had made an excellent re overy from the abdominal surgery and was getting about very well. The vision in the right eye was 20/30, corrected to 20/20 with a lens, minus .75, axis 90. Vision in the left eye was 20/25, corrected to 20/20 with a lens, plus .50 minus 1.00, axis 60. There was an exophoria of 6 prism diopters at 25 cm. In the right eye the anterior chamber was shallow. There was an atrophic iris. Immature cataracts were found in each eye. The media was otherwise clear in each eye and the fundus arteries were moderately attenuated.

The patient was asked to eliminate tea and coffee from her diet and was given Rutin, 20 milligrams a day.

It was found that 1 to 1,000th epinephrine pack, under the upper lid, would temporarily reduce the tension to 19, Schiotz, in each eye. However, within a few days the tension would be between 35 and 40, Schiotz, in the right eye. During this time visual fields were done which showed some constriction of the upper and lower fields with a definite scotoma temporally right eye. It was felt that this might possibly be the beginning of a ring scotoma.

The patient became sensitized to eserine about a month after leaving the hospital. In view of her recent abdominal surgery, the nausea and vomiting were a point of important differential diagnosis. The nausea and vomiting stopped when the eserine was discontinued. The therapy was changed to pilocarpine 1 per cent in the right eye three times a day and in the left eye once a day. The tension remained between 35 and 40, Schiotz, in the right eye for the next few weeks. It was felt that this type of tension was a threat to the vision of the right eye and it was suggested that she have surgery to prevent further damage to the retina. Corneosclerectomy was done, which resulted in good control of the tension of the right eye.

SUMMARY

This case is an interesting incident in which an acute glaucoma that occurred during convalescence from extensive abdominal surgery was safely controlled by miotics until ophthalmic surgery could be performed.

SPONTANEOUS RUPTURE OF THE ESOPHAGUS — A CASE REPORT

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SPONTANEOUS rupture of the esophagus is uncommon. Eliason and Welty[1] reported three cases and reviewed the literature on the subject collecting forty-one previously reported cases. The purpose of this paper is to report a case and to emphasize some points brought out by these authors.

FIRST ADMISSION: HISTORY AND PHYSICAL FINDINGS

N. P., a fifty-eight year old white male was first admitted to the Middlesex Hospital, November 6, 1946, complaining of hematemesis which began suddenly 24 hours previously and had continued at frequent intervals. He had also had numerous tarry stools. He had become very weak and collapsed at home where he was seen by his physician and immediately referred to the hospital. The positive physical and laboratory findings on admission showed a well developed, well nourished, middle aged male with an anxious expression. He was cold, pale and perspiring profusely. B.P. 100/70, P. 100, Hgb. 6.5 gms. (photolometer) RBC 2,380,000 and WBC 16,000 per cmm. with 75 per cent lobulated polynuclears, 10 per cent non lobulated polynuclears and 15 per cent lymphocytes; tarry stools which were positive for occult blood.

PROGRESS AND TREATMENT

He was given a transfusion of 500 cc of compatible blood on admission and put on a soft diet. There was no further nausea or vomiting. A second transfusion of 500 cc of compatible blood was given after 48 hours. No occult blood was found in the stools after the fourth day. A gastro-intestinal series showed a gastric ulcer on the greater curvature in the prepyloric area and a gastric diverticulum. There was no further evidence of hemorrhage and patient was discharged on the 15th hospital day on a two to four week ulcer diet and amino acids.

SECOND ADMISSION: HISTORY AND PHYSICAL FINDINGS

The patient's second admission was at 2 P. M. on December 15, 1946, approximately four and one half weeks after discharge. He had been getting along well at home on his ulcer regime. At 3 A. M. the morning of admission he was awakened with a dull pain in his epigastrium. He was up and about as usual during the morning until about 11 A. M. when he vomited a moderate amount of fresh blood. He was referred into the hospital by his local physician. While riding to the hospital he again vomited and was almost simultaneously seized with severe stabbing epigastric pain and went into shock.

Physical examination on admission showed a well developed and fairly well nourished, middle aged male appearing acutely ill and suffering severe pain. T 100°, P 120, R 30, B.P. 130/80. The skin was moist and cool. There was marked tenderness in the epigastrium with spasm of the upper recti muscles, more marked on left. Hgb. 9.5 g (photolometer) RBC 4,280,000 per cmm. moderate hy chromia, WBC 31,300, per cmm. with 75 per cent lobula polynuclears, 14 per cent non lobulated polynuclears, per cent lymphocytes and 1 per cent eosinophiles.

PROGRESS AND TREATMENT

A diagnosis of ruptured gastric ulcer was made a operation begun within two hours after admission. T patient was in a state of shock in spite of the administrati of 500 cc of saline, 500 cc plasma and 500 cc of compatil blood. Exploration of the peritoneal cavity, a gastrotor and instillation of methylene blue into the stomach reveal no evidence of a ruptured ulcer or any pathology to a count for the severe pain. His condition remained poor po operatively and his pain continued to be exquisite in sp of the administration of morphine and demerol. He expir at 4 A. M. the following morning, 25 hours after the on of the acute symptoms and 14 hours after admission.

AUTOPSY

At autopsy a longitudinal rent 3.5 cm. in length was fou on the left posterolateral wall in the lower end of t esophagus completely perforating it—with a second rent the posterior wall penetrating only the mucosa and measu ing 4 cm. in length. The mucosa was stained blue (meth lene blue introduced through Levine tube at operatio and the rent was surrounded by a zone of necrosis a hemorrhage. On opening the left pleural cavity, air w heard to escape and 1800 cc of coffee ground materi was found in the pleural cavity. The visceral and pariet pleura were stained blue and there was collapse of tw thirds of the left lung.

FINAL DIAGNOSIS

Pneumo-hemo thorax with collapse of left lung and spil age into the left pleural cavity from a ruptured esophagu

Pre-pyloric ulcer on greater curvature of stomach wit false diverticulum.

Recent operative gastrotomy.

Arteriosclerotic nephritis.

Carcinoma of the prostate-localized-Stage I.

DIFFERENTIAL DIAGNOSIS

The previous history and diagnosis of a pre-pyloric ulce with the present acute symptoms certainly pointed towar the diagnosis of a ruptured peptic ulcer. Other diagnose to be considered were coronary occlusion, acute pancrea titis, mesenteric occlusion and dissecting aneurysm. Thes latter three diagnoses were ruled out at operation. Coronar occlusion was considered as a possible diagnosis but th pulse remained strong and regular and no relief could b obtained by medication. The diagnosis of rupture of th esophagus was not considered pre-mortem. This was als

ne in those cases reviewed by Eliason and Welty[1] as in ly four of the 44 cases was the diagnosis made pre-rtem. The diagnosis might have been made in this case a flat plate of the abdomen and a chest plate had been ken for it would have shown air and fluid in the left eural cavity with collapse of the left lung and mediastinal physema.

CUSSION

This was a typical case of spontaneous rupture of e esophagus. The rupture usually occurs at the wer end of the esophagus, usually on the left sterolateral wall, usually is one to several centi-eters in length and often rupture into the left eural cavity occurs during attacks of vomiting. he etiology is not entirely clear but Eliason and elty[1] state that the most important factor in ontaneous rupture of the esophagus is that of a dden increase in pressure. Weiss and Mallory[2,3] oduced linear fissures of the lower esophagus by creased pressure. Weiss[4] postulated that it is pos-le for vomiting to cause increased pressure and a pture of the esophagus.

Clinically this patient showed the typical findings spontaneous rupture of the esophagus: an episode vomiting, sudden severe pain in upper abdomen d epigastrium, continued vomiting, profound ock. Chest signs of air and fluid in the left pleural vity might have been picked up on physical exam-ation and by x-ray examination if they had been searched for. About half of the cases show subcutaneous emphysema which this case did not show. The mortality rate is practically 100 per cent, most of the patients dying within 24 hours from a fulminating mediastinitis.

SUMMARY

The diagnosis of spontaneous rupture of the esophagus should be considered in a differential diagnosis of a patient with severe upper abdominal pain and shock. The diagnosis can be made clinically from the history, plus a search for mediastinal emphysema and signs of rupture into the pleural cavity. Advances in surgery, in anesthesia and in the treatment for shock plus the use of chemotherapeutic agents should lower the mortality rate. Recoveries in cases of ruptured esophagus may be obtained if the diagnosis is recognized promptly and early surgical treatment instituted.

BIBLIOGRAPHY

1. Eliason, E. L., and Welty, R. F.: Surg. Gyn. Obst. 183:234-238, 1946.

2. Mallory, G. Kenneth, and Weiss, S.: Am. J. M. Sc., 178:506-515,1929.

3. Weiss, S., and Mallory, G. Kenneth: J. Am. M. Assoc., 98:1353-1354, 1932.

4. Hatcher, R. A., and Weiss, S. J.: Pharm. Exp. Ther. 22:139-193, 1923.

HREE CASES OF PEMPHIGUS IN THE SAME FAMILY: REPORT OF ONE CASE

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N RARE instances the report of more than a single case of pemphigus in the same family has been eorded.[1] The following case is of interest because represents such an occurrence.

SE REPORT

A 64 year old Jewish housewife was admitted to the ckaway Beach Hospital because of a sore mouth, hoarse-ss and skin eruption of three months duration.*

Her mother died of tuberculosis at the age of 70 and her her had bronchial asthma. Two brothers died of pem-igus, the first at Bellevue Hospital in 1915 at the age 57 and the other at Kings County Hospital in 1932 at e age of 58 after an illness of several months.

Six months before admission to the hospital she first observed some "sores" in her mouth. At that time she was supposed to have had a "trench mouth." Treatment by several physicians gave no relief. Gradually the ulcers spread to her throat and there was difficulty in swallowing. At that time she also developed a slight cough and hoarseness.

Physical examination on admission revealed a well developed and well nourished woman of 64 years. She had multiple painful ulcerations of the bucal mucosa, lips, pharynx and tongue which were covered by a white membrane. The axilla, back, groins, genitalia, perineum and the extremities were covered by imperfectly formed flaccid bullae and a generalized exfoliation. Nikolsky's sign was present (the epidermis is easily removed by pinching the skin, leaving a raw surface).

The body temperature was 103 F., the pulse rate 95 and the respirations 24 per minute. The blood pressure was 130 mm. systolic and 90 mm. diastolic. The heart sounds were poor and regular and there was a loud aortic systolic murmur. The lungs had a few scattered râles at both bases.

*The patient was seen in consultation with Dr. Jack Wolf d Dr. Emanuel Appelbaum.

The abdomen was soft, there were no masses; the spleen could be easily palpated. The knee jerks were exaggerated. The optic discs showed a bitemporal pallor. There was a marked tremor of both hands. The fingers and toes showed a thickening of the nails due to heaped up crusts beneath them; they were friable and easily eroded. Paronychial inflammation and scaling was evident.

Routine laboratory data revealed the following: red blood count 4,250,000, hemoglobin 72 per cent, white blood cells 8,150 (polymorphonuclear cells 68 per cent, eosinophiles 22 per cent, and lymphocytes 10 per cent). Urine was normal. Three blood cultures showed no growth. The total serum protein was 6.7 per cent; albumin 4.3 per cent; and globulin 2.4 per cent, all of which were within normal range. Serum calcium was 11 mgs. per 100 cc. of blood. Blood chlorides were 493 mgs. per 100 cc. of blood. Mazzini test was negative. Non protein nitrogen was 32.8 mgs. per 100 cc. of blood. Sedimentation rate (Westergren) was 58 mm. per hour. Prothrombin time undiluted was 13.5 seconds and diluted (⅛) 34.5 seconds. Blood cholesterol was 150 mgs. per cent. X-ray of the chest showed a slight clouding of the left base with no evidence of any fluid or consolidation.

Culture of a swab from the mouth with blood agar plates, dextrose broths, deep agar shake tubes and cooked meat with vaseline seal revealed a predominance of non hemolytic streptococcus; two types of alpha streptococcus; gram negative micrococcus of M catarrhalis group. Culture was negative for anaerobic bacteria. Culture of swabs from lesions of the thigh with blood agar plates, dextrose, broths, deep agar shake tubes and cooked meat with vaseline seal and Loeffler's medium showed a predominance of hemolytic streptococcus; staphylococcus aureus; beaded gram positive rods of Corynebacterium groups; large gram positive micrococcus of non pathogenic type. There were many colonies in the third dilution plate. The cultures were negative for anaerobic bacteria.

The clinical picture was that of pemphigus vegetans. (Figure 1.)

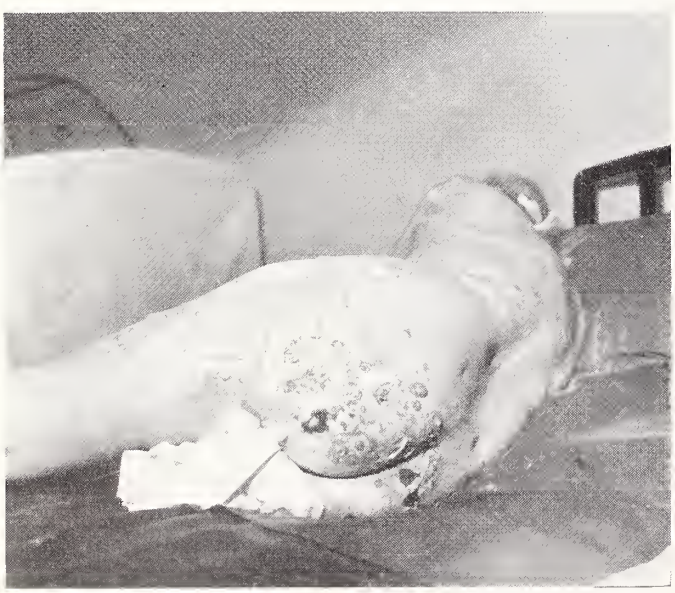


FIGURE 1

To combat the toxemia due to the secondary infectio 50,000 units of penicillin were given parenterally ever three hours and transfusions of 250 cc. of whole bloo given every other day for four days. She was put on high protein diet supplemented with large doses of vitamin with each meal: 250 mgs. nicotinic acid, 50,000 units vitami A, 1000 mgs. vitamin C and two teaspoonfuls of yeas powder in tomato juice, plus 30 drops of oleum percomorph After two weeks penicillin was discontinued and strepto mycin (2 grams in divided daily doses) intramuscularl was given for two weeks. Nutrition was well maintaine throughout the course of illness. The skin lesions and gen eral condition gradually improved. She was discharge from the hospital six weeks after admission. The previou sites of the bullous lesions were replaced by areas of hyper pigmentation. (Figure 2.)*



FIGURE 2

DISCUSSION

The term pemphigus (blister) is a definite systemic non contagious disease of adult life and has as its most prominent feature a characteristic primary non inflammatory bullous eruption of the cutaneous and mucous surfaces of the body.[2]

The disease is rare. It occurs once or twice in every thousand cases of skin disease. True pemphi-

*Patient died November 1947 at Kings County Hospital, Brooklyn, New York, 16 months after the onset of her illness.

gs does not occur in children and is a disease of adult life occurring between the ages of 30 and 70 years. It is widely distributed being reported from all parts of the tropical and temperate zones, especially from areas where crowding, poverty, and poor nutrition abound.

Bacteriological investigations have led to no generally accepted conclusions and the disease is not generally believed to be hereditary or contagious. The symptoms of the disease are probably caused by a toxic agent affecting the nervous system, skin, and mucous membranes.

Recently it has been suggested that pemphigus may be a deficiency disease which, like pellagra and beriberi, is due to the absence of some nutritional element the lack of which is manifested in the nervous system and skin. For example, in beriberi there is an edematous condition of the skin and in pellagra there is a bullous skin lesion.

The typical eruption of bullae is usually the first manifestation of the disease. These appear on the face, mouth, and anogenital region. The bullae occur single or irregularly or in groups, each developing fully within a period varying from a few hours to 24 hours. They are at first usually filled with clear serum without a noticeable preliminary erythema and from an apparently normal skin. These blisters vary from a pea to an egg in size and there may be a few or they may cover the entire body. The eruption is bilateral. The blebs breaking excoriated surfaces.[3]

The peculiar disagreeable odor comes from the decomposition of the epithelial cells and from the secretion. Nikolsky's sign may be present. The subjective complaints are of a burning sensation; tenderness and stiffness in the involved areas; marked weakness and exhaustion. Ulceration may occur in any of the mucosal areas.

SUMMARY AND CONCLUSIONS

Three cases of pemphigus are recorded in one family, two brothers and a sister, all occurring in the fifth and sixth decade. The patient described had a temporary remission of symptoms partly because her nutrition was well maintained and probably because remissions are characteristic of the disease. The great variety of organisms isolated lack sufficient evidence as being the causative agents and were undoubtedly secondary invaders. Etiological agents, whether a virus or an intrinsic deficiency factor or an allergy, are still unknown. The search will continue and stands as a challenge to modern medicine.

BIBLIOGRAPHY

1. Hyman, H. T.: An Integrated Practice of Medicine. Vol. IV, p. 3405, W. B. Saunders, Phila., Pa.

2. Cyclopedia of Medicine. Vol. 9, pp. 717, 1937, F. A. Davis Co. Phila., Pa.

3. Sulzberger, M. B., Wolf, J., Dermatologic Therapy In General Practice. Year Book Publishers, Inc. Chicago, Ill. 1942, p. 362.

With the technical assistance of Miss M. Michalek.

EXPERIENCE WITH THE USE OF NITROGEN MUSTARD AT THE HARTFORD HOSPITAL

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Since July 1946 nitrogen mustard has been made available to the Hartford Hospital by the National Research Council for clinical use in selected cases of the lymphomata, polycythemia vera and advanced lung cancer. This agent has been used on 21 patients (Table I), all of whom were hospitalized. It is felt that a sufficient number of cases have been treated to justify a preliminary report on the relative therapeutic efficacy of this agent in the management of a restricted category of neoplastic disease.

Toxicological studies[1] of mustard gas by the Chemical Warfare Service of the United States Army during World War II revealed that certain derivatives of this toxic gas, notably tris-(B-chloroethyl) amine hydrochloride and methyl bis-(B-chloroethyl) amine hydrochloride had biological therapeutic qualities which suggested their use in certain forms of human cancer. More specifically, primative tissues and abnormal hematopoietic cells show specific affinity for this agent. Initially, this agent was cautiously used in several clinics, and re-

ports[2,3,4,6] from these institutions have summarized their experience.

Our experience has been limited to the use of methyl bis (B-chloroethyl) amine hydrochloride, since there is less danger of venous thrombosis with this agent. Before treatment each patient had a complete blood count, urinalysis and appropriate roentgen and photographic studies. Sternal marrow aspiration and biopsy of prevailing nodes or other tissue was done to establish diagnosis. Preliminary or complementary transfusions were given as indicated. Careful check was made of opiates and sedatives necessary for control of pain, pruritus and discomfort before treatment.

The prescribed daily intravenous dose was 0.1 mgm. per kilogram of body weight. Four daily treatments constituted the usual course, though occasionally treatment would be withheld on the 3rd day when occasioned by pronounced nausea and vomiting.

When dissolved in aqueous solution this inert powder becomes an ethylene-immonium derivative which is physiologically active. Ten c. c. of sterile isotonic saline were added to a sterile ampule containing 10 mgm. of this drug, and immediately the appropriate dose was withdrawn and injected into the rubber tubing of an intravenous set delivering saline and glucose. Preliminary sedation was assured by use of a nembutal rectal suppository. The only immediate toxic effects encountered were nausea and vomiting of varying severity. During treatment, complete blood counts and smear were done every 2nd day. On discharge, the patients were requested to return at regular 2-4 week intervals for clinical evaluation, follow up blood counts, and post treatment x-rays or photographs.

It is important to stress the toxic reactions, and to emphasize the relatively narrow margin of safety attending the use of this agent.

The immediate reaction commonly encountered is nausea and vomiting of varying severity and duration. It was noted in 75 per cent of this group, and in no case did it result in dehydration or shock. Anorexia during treatment was a common finding. One patient experienced severe thrombophlebitis with fibrosis of the antecubital fossa following extravasation of this agent into the soft tissues. No diarrhea or febrile response was noted.

The late toxic effects are predicated on the specific affinity for this compound demonstrated by primitive cells in lymph nodes and the hema- poietic system. Large initial doses, or several cou- closely administered, allowing insufficient time recovery of the blood forming organs may resul leukopenia, thrombocytopenia and moderate nor chromic anemia. Occasionally complete aplasia the bone marrow and widespread destruction lymphoid tissue may result. When these toxic d are administered, lymphocytes disappear first fr the circulating blood followed by decrease and t absence of neutrophiles and leukopenia; throm cytopenia with purpura is then noted, and la moderate anemia. These delayed toxic effects p clude the general use of this agent, and are a c stant reminder that the main object in treatmen to keep the dosage within the narrow range of saf so as to achieve the maximal clinical effect wit minimum of bone marrow depression. In this ser we have encountered one specific instance of leu penia and thrombocytopenia resulting in de (Case V). It should be noted that recovery of marrow from these toxic effects is not favora influenced by antibiotics, liver, iron, pentonucl tide or folic acid. Whole blood transfusions are u ized for their temporary stabilizing effect.

Clinical Results

Table 1

Hodgkin's disease	10
Lymphosarcoma	4
Chronic lymphatic leukemia	2
Subacute lymphatic leukemia	1
Inoperable cancer of lung	4
Mycosis Fungoides	3
Polycythemia vera	1
Breast cancer	1
Carcinomatosis—gastro-intestinal	1
Total	27

It is apparent that this series is too small to w rant statistical analysis or comparison with roentg irradiation. Furthermore, the majority of th cases were terminal or refractory to radiation, a were selected for this therapy when no other tre ment suggested itself. All but 2 patients had h previous surgery and/or x-ray treatment.

For this reason, we will attempt to report mai in case history form our experience in these vari categories, and to correlate this experience with t of other investigators. It is hoped that this meth will clarify the role of the nitrogen mustards in treatment of these specific neoplastic diseases.

HODGKIN'S DISEASE

It should be emphasized that in early Hodgkin's disease, with slowly progressive or localized involvement, x-ray is the therapy of choice. However, should this disease become refractory to x-ray, or rapidly widespread with fever, anorexia, weight loss, weakness, pruritus and occasionally jaundice, the use of localized x-ray may not achieve satisfactory remission. It is suggested, on the basis of a large series of cases from other clinics and our own limited series, that nitrogen mustard can produce significant and often dramatic remissions for intervals of 2 weeks to several months, characterized by subsidence of fever, restoration of appetite, strength, weight and regression of all palpable adenopathy. Occasionally decrease in pulmonary pathology, relief from pruritus, and alleviation of bone symptoms due to proven skeletal metastases is noted. Subsequent relapses may respond to this treatment, but these remissions are of shorter duration, and in general, the more acute and rapidly progressive the disease, the shorter and less complete are the remissions.

CASE I

Mrs. R. R., 30 year old housewife. 1943, onset of diffuse peripheral lymphadenopathy. Cervical lymph node biopsy revealed Hodgkin's disease. X-ray therapy resulted in good initial response. 1944, onset of cough, chest pain and dyspnea with roentgen evidence of hilar adenopathy which responded to x-ray. 1945, low back pain, abdominal discomfort and swelling relieved by x-ray.

In spring of 1946 progressive pruritus, cough, weakness. Admitted to Hartford Hospital in October 1946. Enlargement of all peripheral nodes and many discrete adbominal masses found on physical examination. Skin excoriated from scratching. Chest film revealed bilateral hilar adenopathy and infiltration of the right lower pulmonary field. Blood count not unusual. Vital signs normal. Intravenous novocaine, sedation, and dermatological preparations affords no relief of pruritus.

A course of nitrogen mustard in October 1946 was followed by complete regression of all peripheral and abdominal nodes, relief of pruritus, together with healing of skin excoriations, and complete resolution of all pulmonary pathology. The blood was not unfavorably affected. Patient restored to useful life and duties for the first time in 2 years. Follow up confirmed this favorable course of events until January 25, 1947, when, though asymptomatic, chest film revealed recurrence of pulmonary pathology.

In March 1947, 6 months after first course of nitrogen mustard, pruritus, asthenia and peripheral and abdominal adenopathy were noted. Patient readmitted to hospital in April 1947 for 2nd course of therapy. Regression of nodes was as complete, though pruritus again relieved and supplementary x-ray given to left neck and axilla with good regression in these previously resistant nodes. Two subsequent courses of nitrogen mustard were given in July and September 1947, each with less complete remission, and at present, November 1947, patient has some residual cervical adenopathy which is being treated with x-ray.

This abbreviated case report illustrates a dramatic remission induced in a radiation resistant case of Hodgkin's disease with rehabilitation of a housewife to useful family life for many months.

CASE II

J. A., 20 year old white male with history of mediastinal and bilateral cervical adenopathy, proven to be Hodgkin's by biopsy in November 1945. Course of deep x-ray therapy in January 1946 with good initial response. May 1946 onset of cough, dyspnea, weakness, abdominal fullness and jaundice with light stools and dark urine. Admitted to Hartford Hospital June 1946. Roentgen studies demonstrated right hydrothorax. Jaundice, liver enlargement, ascites and dilatation of abdominal and thoracic wall veins noted. Peripheral nodes palpable, but not prominently enlarged. Deep x-ray therapy started to chest and abdomen, but patient continued to be febrile, nausea and vomiting prominent and jaundice persisted. Hydrothorax reaccumulated despite successive thoracenteses.

July 1946, course of nitrogen mustard given. Temperature dropped to normal, white blood count 3,550, peripheral nodes regressed completely and dilated veins on abdominal and chest walls disappeared. Liver decreased in size, jaundice cleared, cough and dyspnea less troublesome. Patient discharged and was well for 3 months.

November 1946 readmitted because of cervical and axillary adenopathy, fullness of right pectoral fold and dilation of thoracic wall veins associated with dyspnea, cough and malaise. No jaundice or hepatomegaly noted. Right hydrothorax confirmed by x-ray. Blood count normal and patient febrile. November 6-9, 1946, second course of nitrogen mustard with regression of peripheral cervical nodes and softening of pectoral tissues. However, 6 weeks later, patient readmitted because of fever, malaise, dyspnea and orthopnea. Recurrent generalized lymphadenopathy, hepatomegaly, right hydrothorax and anemia noted. Despite third course of nitrogen mustard December 20-23, 1946, thoracentesis and supportive treatment, patient failed to respond and expired on January 22, 1947. Unfortunately postmortem could not be secured.

A dramatic response to nitrogen mustard was obtained in this acutely ill white male with resolution of all nodes, drop in temperature, restoration of normal liver function, clearance of jaundice and dimunition of rate of fluid accumulation, with rehabilitation for 3 months. However, subsequent treatment was not effective in preventing further recurrence.

CASE III

M. B., 38 year old white single nurse. 1944, bilateral axillary and cervical adenopathy associated with mediastinal disease. Proven Hodgkin's disease by biopsy of axillary

node. Received deep x-ray to mediastinum, axillae and neck with good initial response. Well until 2 years later. January 1946, onset of progressive fatigueability, cough, pruritus, night sweats and upper abdominal discomfort. Admitted to Hartford Hospital August 1946, where mediastinal and generalized peripheral adenopathy noted. No definite abdominal masses noted and blood count not abnormal. Vital signs normal.

August 26-30, 1946, course of nitrogen mustard with good regression of peripheral and mediastinal nodes. Blood count not adversely affected. Symptomatically patient improved, and in subsequent follow up general condition has remained good, permitting patient to carry on with all household duties. At present, 15 months after treatment, she has but small single discrete nodes in the right axilla and neck.

Good symptomatic and therapeutic response in a slowly progressive case of Hodgkin's disease is noted with restoration of patient to good health for 15 months.

LYMPHOSARCOMA

The pleomorphic nature of this disease precludes any predictable clinical course, and it is likely that nitrogen mustard will not prove to be consistently successful in inducing remissions quantitatively or qualitatively. In the rapidly progressive and clinically aggressive lymphosarcomata, remission with this agent are of short duration, and subsequent recurrences respond poorly. However, the slowly progressive lymphoma with or without an elevated white count and generalized lymphadenopathy will respond more satisfactorily. Two cases illustrating these findings follow:

CASE IV

D. W., 64 year old housewife. November 1945 bilateral cervical and axillary adenopathy treated with deep x-ray at Hartford Hospital following biopsy of cervical node which revealed malignant lymphoma. Blood count, chest film essentially normal at this time. Good regression following treatment, but progressive weakness, dyspnea and anorexia noted despite transfusions.

November 1946, readmitted to Hartford Hospital where daily remittent fever of 99 to 103.6, and shortly cervical and axillary adenopathy noted with associated spleno and hepatomegaly. Hemoglobin 4.2 grams (31 per cent) and hematocrit 16.5. White blood count 3,200 with essentially normal smear and platelet distribution. Sternal marrow biopsy revealed "suppression of granulocytes with overactivity of erythroid series. No infiltration of marrow by tumor cells." Chest film negative for mediastinal widening or pulmonary infiltration. With the aid of several blood transfusions, hemoglobin elevated to 7.75 grams (50 per cent) and hematocrit 25. White blood count 4,500 with no significant change in smear.

Since this patient was bedridden, gravely ill, and with a proved diagnosis of malignant lymphoma, it was decided to treat her cautiously with nitrogen mustard. She received a half dose of nitrogen mustard followed by a three quarter dose and the 3rd day received a full dose of nitrog mustard. She refused any further treatment because of t moderate nausea and vomiting induced by this agent. H white blood count after this incomplete course was 3,5 with a smear essentially unchanged. Her subsequent clinic course was not spectacular, but her temperature did dr to normal, regression of palpable nodes was noted, a gradually she was permitted up in a chair, became ambu tory and was discharged 6 weeks after her treatment.

Her subsequent clinical course showed continued restor tion of health. She has been up and about. Hemoglobin ro to 80 per cent, she has been active at home and out doors. In May of 1947 a subcutaneous nodule was not medial to the right clavicle which responded to x-ray. Sl has subsequently continued to do well and her positive fin ings at present consist of a moderate anemia with son hepato and splenomegaly. Fibrosis and scarring of the rig antecubital fossa followed extravasation of a small amou of nitrogen mustard.

This case illustrates dramatic rehabilitation of gravely ill patient. Her subsequent course justifie use of this agent.

CASE V

59 year old housewife. February 1947 onset of cervic and axillary adenopathy, proven lymphoblastic lymphon by biopsy of cervical node. Deep x-ray produced regressi of peripheral nodes, but weakness, anorexia and low gra fever persisted. Subsequently, abdominal discomfort, nause vomiting were noted.

On admission to Hartford Hospital July 1947, large clu ters of lymph nodes found in all node bearing areas, liv enlarged and chest film revealed a right paratracheal mas Blood count, EKG and serology normal. Daily remitte temperature of 99° to 103° recorded.

July 19-24, 1947 course of nitrogen mustard. Temperatu dropped to normal within 24 hours and remained so fo remainder of hospital stay. Initial white blood count 10,20 with normal smear. Ten days after treatment, white bloo count, 2,500 and remained at this level. All nodes regresse nicely and patient was comfortable except for moderat asthenia. Subsequent chest film revealed complete regressio of right paratracheal mass.

However, 6 weeks later, September 1947, patient note onset of abdominal discomfort, nausea, low grade fever an recurrence of peripheral adenopathy. In addition, che film demonstrated right paratracheal mass. Laboratory dat hemoglobin 11.5 grams, hematocrit 33, white blood cou 4,900. September 5-9, 1947, second course of nitroge mustard. White count dropped to 1,750. Despite regressio of some peripheral nodes, nausea, low grade fever, abdom inal distension associated with jaundice persisted. Despit penicillin, whole blood and general supportive treatmen white blood count dropped to 200, platelets disappeared and thrombocytopenic manifestations were noted. Patien expired September 22, 1947. Postmortem demonstrate residual lymphoblastic lymphoma involving mediastinal an abdominal nodes, as well as lymphomatous infiltration o liver, spleen, bone marrow and adrenals. In additio hemorrhagic infarcts of the lungs and hypoplasia of bon marrow were striking findings.

This case illustrates good initial response of an aggressive lymphoma, but period of remission was short and recurrent disease responded poorly to this chemotherapeutic agent. The depression of bone marrow by infiltration of disease supplemented by toxic effect of this therapeutic agent resulted in complete depression of the hematopoietic system.

LEUKEMIAS

Dramatic remissions are not the rule with the leukemias. Acute lymphoblastic or myeloblastic leukemias have not responded to this agent, and in some instances exitus has been hastened. Far advanced chronic leukemias associated with severe anemia and diminished platelets respond poorly and provide little margin of safety for treatment. Deep x-ray therapy would appear to be the superior and safer therapeutic agent for leukemias in general, but it should be noted that the slowly progressive cases of chronic lymphatic and myelogenous leukemia with elevated white count, generalized adenopathy and hepato- and splenomegaly will respond to this agent with partial regression of nodes, decrease in size of spleen and liver, and lowering of white count with restoration of hemoglobin.

CASE VI

C. S., 73 year old white male. February 1944—generalized adenopathy associated with weakness and weight loss. Biopsy of cervical node and blood count diagnostic of chronic lymphatic leukemia. Deep x-ray therapy in August 1944 to spleen, peripheral and enlarged mediastinal nodes, followed by clinical and hematological improvement for 9 months. Another course of x-ray given in May 1945 with remission for 14 months.

September 1946—weight loss, weakness, abdominal swelling and dry cough associated with generalized lymphadenopathy, hepato- and splenomegaly, and hematological remission. Started on third course of deep x-ray on October 1946, but tolerated this poorly. November 1946 admitted to Hartford Hospital with clinical findings unchanged over September 1946. Admission blood count: hemoglobin 55 per cent, hematocrit 30.5, white count 223,000, 75 per cent lymphocytes, 5 per cent lymphoblasts, 17 per cent PMN and 3 per cent monocytes and normal platelet distribution. Questionable widening of mediastinum on chest film. November 1-5, 1946, course of nitrogen mustard, and 2 transfusions of 500 c. c. whole blood. Fifty per cent regression of all peripheral nodes, and decrease in size of liver and spleen followed treatment. Hemoglobin 90 per cent, red blood count 4,500,000, white blood count 27,400 with 91 per cent lymphocytes and 9 per cent PMN. Patient continued to do well. March 1947, white blood count 86,800, though patient asymptomatic, and in August 1947, white blood count 75,500. On return in October 1947, white blood count 230,000, 90 per cent lymphocytes, 4 per cent lymphoblasts, 6 per cent PMN and hemoglobin 75 per cent. Peripheral nodes enlarged, hepato- and splenomegaly present, and some deterioration in general condition observed. Patient recommended for 2nd course of nitrogen mustard.

This patient illustrated a 12 month remission of chronic lymphatic leukemia induced by nitrogen mustard. It is likely that judicious x-ray would have accomplished an equally good remission.

INOPERABLE CARCINOMA OF LUNG

A recent analysis[7] of results obtained with nitrogen mustard in the treatment of extensive and inoperable carcinoma of the lung, circulated among investigators using this agent, revealed that 70 per cent of patients receiving this treatment had some regress with favorable clinical response lasting from 3 weeks to 6 months. There was no correlation between the histological classification of the lung tumor and the response to this agent. Symptomatic improvement was characterized by decrease in cough, dyspnea, amount of sputum and increase in strength and appetite. Alleviation of skeletal metastatic pain, reduction of pleural effusion, temporary control of pulmonary lesion and aeration of atelectatic areas were noted, but x-ray studies rarely showed regression of the primary or metastatic lesions. When relapse occurred, subsequent nitrogen mustard treatment usually was not effective. There is no contraindication to use of deep x-ray therapy to complement or supplement this therapy.

We have treated 4 patients who had proven inoperable carcinoma of lung with skeletal metastases. Bone pain was chief complaint in all 4 patients, and in each case, relief was achieved for periods of 4 to 10 weeks. Two patients subsequently expired and postmortem revealed extensive disease with no appreciable change in the microscopic picture of the tumor. Post-treatment radiographs did not demonstrate any regression of the primary or metastatic foci.

CASE VII

H. M., 66 year old male. Three month history of progressive and severe skeletal pain with minimal pulmonary symptoms. X-rays revealed multiple osteolytic lesions associated with a large right lower lung lesion. Bronchoscopy negative, but Papanicolaou stain of secretions from right main bronchus positive for carcinoma.

July 4-9, 1947. Course of nitrogen mustard given with excellent relief of all pain except left hip for which supplementary deep x-ray was given with good symptomatic response. Patient comfortable for 8 weeks, at which time recurrence of general skeletal pain noted. No further nitrogen mustard was given.

Satisfactory temporary palliation achieved for 8 weeks, though recurrence of symptoms makes any enthusiasm for this treatment tenuous.

MYCOSIS FUNGOIDES

Inasmuch as this disease entity is a form of lymphoma involving the skin, one should expect it to be favorably affected by nitrogen mustard, and this has been borne out in the experience of other investigators as well as in our small series of 3 cases. X-ray therapy has been pre-eminently successful in controlling the growth of the early localized cutaneous lesions, but many of these patients eventually present widespread skin involvement or localized radio-resistant lesions, so that x-ray is no longer effective or practical. It is this group of patients who have responded to nitrogen mustard with remissions lasting several months or longer.

CASE VIII

R. S., 52 year old white housewife. Onset of exfoliative dermatitis in 1942. Skin biopsy at Massachusetts General Hospital September 1945 reported "Mycosis fungoides" and low voltage x-ray therapy started in Boston with good initial result, and continued at Hartford Hospital in March 1946 when recurrence noted. Large bullous nodules, some intact, others ulcerated, replaced about 75 per cent of the entire body skin surface. Complete hospital workup negative except for moderate hypochromic anemia with leukocytosis. Though these lesions responded to x-ray, successive new lesions would appear, so that after 6 months of close follow up and careful persistent therapy, it appeared that x-ray could not control the disease.

On admission to Hartford Hospital January 13, 1947, about 80 per cent of entire skin surface was replaced by nodular and ulcerated lesions 3 to 20 cm. in diameter—some exposing underlying fat, muscle and bone. Marked facial edema and swelling noted. All peripheral node bearing areas contained clusters of enlarged nodes. Chest film negative except for slight widening of upper mediastinum. Vital signs normal. Moderately severe anemia noted. She was confined to bed and suffered considerable pain from these ulcerating nodules.

January 18-22, 1947, course of nitrogen mustard supplemented with several transfusions. Subsequent follow up revealed resolution of all peripheral nodes and subsidence of facial edema. Approximately 80 per cent of all involved skin areas regressed or healed and epithelized. She was up and about doing light housework.

On April 2, 1947, 2 recurrent nodules were noted on skin of neck and right upper arm. April 30, 1947 patient readmitted to Hartford Hospital because of vague cerebral symptoms and recurrence of cutaneous lesions. Her condition rapidly deteriorated, coma supervened, and she expired on the 3rd hospital day. Postmortem revealed a subarachnoid hemorrhage, splenomegaly with infarcts and generalized abdominal adenopathy suggesting Hodgkin's disease on microscopic examination.

Dramatic resolution of disease with rehabilitat of this patient for 10 weeks followed use of nitro mustard in a previously hopeless situation.

MISCELLANEOUS

We have successfully treated 1 case of sev polycythemia vera with nitrogen mustard. He continued to do well during past 9 months. Thi confirmed by the experience of other investigato Two patients with widespread carcinomatosis, from primary breast and other primary unkno though probably gastro-intestinal, failed to respo significantly to this agent.

COMMENT

Inasmuch as nitrogen mustard produces alterati in cellular structure similar to those produced x-ray irradiation, it is not surprising that simi qualitative clinical results are observed. Howev this drug offers a form of acute total "body irrad tion," and therefore has been reserved for hopel and terminal cases who have become refractory x-ray, or whose disease is so extensive that continu and prolonged use of x-ray seems inadvisable.

Our series is too small and too largely restrict to hopeless and advanced cases to warrant compa son with any other modality of treatment. It apparent that in susceptible cases encouraging a dramatic remissions from 10 days to 14 months ha resulted, with occasional temporary restoration useful life. It must be emphasized that no cu have been claimed for or recorded following the u of this agent.

On the basis of these observations there is litt doubt that x-ray therapy is still the treatment choice for localized lymphomata, since the marg of safety is greater and this therapy can be giv locally. However, once the particular disease b comes refractory to irradiation, or too extensi for local treatment, nitrogen mustard suggests itse as a useful therapeutic agent.

With a view to the future of "chemotherapy" the treatment of cancer, it is well to remember th this drug represents but one of a series of con pounds which are being carefully studied with view to altering various prosthetic and substitue groups in their structure. This systematic and pain taking analysis may yield a compound or con pounds which will induce longer remissions with wider margin of safety. The next step in this proce might yield an agent capable of permanent eradic tion of specific neoplasms.

SUMMARY

Since July 1946 a series of 27 patients with neoplastic disease have been treated at Hartford Hospital with methyl-bis (B-chloroethyl) amine hydrochloride. Established diagnoses of treated cases were Hodgkin's disease, lymphosarcoma, chronic lymphatic leukemia, mycosis fungoides, polycythemia vera, inoperable bronchogenic carcinoma and widespread carcinomatosis from the breast and gastrointestinal tract.

2. Immediate toxic reactions of nausea and vomiting were of varying severity, but in no case resulted in shock or dehyration. One death can be directly attributed to the late toxic effect on bone marrow with resulting neutropenia and thrombocytopenia.

3. Favorable and dramatic clinical remissions in advanced and terminal cases have lasted from 10 days to 14 months. The best results were obtained in Hodgkin's disease, but significant palliation was achieved in lymphosarcoma, chronic lymphatic leukemia, mycosis fungoides and advanced metastatic bronchogenic cancer.

4. Nitrogen mustard is not a cure for any type of neoplastic disease studied to this date.

5. X-ray therapy is still the superior modality of treatment in lymphomata and allied diseases of the hematopoietic system.

REFERENCES

1. Gilman, A. and Philips, F. S.: Biological Actions and Therapeutic Applications of the B-chloroethyl Amines and Sulphides. Science 103, 409-415, 1946.

2. Rhoads, C. P.: Nitrogen Mustards in the Treatment of Neoplastic Diseases. J.A.M.A. 131, 656, June 1946.

3. Jacobson, L. O., Spurr, C. L., Guzman-Barron, E. S., Smith, T., Lushbaugh, C., and Dick, G. F.: Nitrogen Mustard Therapy. J.A.M.A. 132, 263, October 1946.

4. Goodman, L. S., Wintrobe, M. W., Dameshek, W., Goodman, M. J., Gilman, A., and McLellan, M. T.: Nitrogen Mustard Therapy. J.A.M.A. 132, 126, September 1946.

5. Jacobson, L. O., Spurr, C. L., Guzman-Barron, E. S., Smith T.: Cancer Research 7, 51, January 1947.

6. Taffel, M.: Experiences in the Treatment of Neoplastic Disease With Nitrogen Mustard. Yale Journal of Biology and Medicine, 19, 971, 1947.

7. Abstract of Protocols Released by National Research Council.

EVIDENTIAL TRENDS IN DIAGNOSTIC ACTIVITIES IN PUBLIC HEALTH LABORATORIES

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TWENTY-FIVE years ago outbreaks of infectious diseases were common in New England and much of the emphasis in laboratory work was directed toward control of diphtheria and typhoid fever. Many laboratories then were examining large numbers of throat and nose cultures from school children and from contacts of cases in order to find carriers. At that time smears only were being examined for gonorrhea and smear examinations only were being made of sputum for tubercle bacilli. It is almost startling to pause now and realize how few and uncomplicated were the tests carried on in most diagnostic laboratories twenty-five years ago. A trend is evident when we contrast the situation at that time with the activities in the diagnostic laboratory today.

In the modern public health laboratory we find ourselves now dealing less with outbreaks of disease and giving more attention to the sporadic case. The culturing of the clot remaining from an agglutination test in many an instance will yield a culture of typhoid or another *Salmonella* or show that the causative organism of brucellosis is present. Special study of a case of acute gastroenteritis or diarrheal disease frequently reveals the cause to be a *Salmonella*, a *Shigella* or a member of an allied group of bacteria. Today the laboratory director is often in a position to suggest more work on a patient when it seems necessary. In fact, it is customary to advise the physician that additional specimens should be

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examined when there is indication they will be of value.

The use of the central laboratory of the state health department to complete many examinations that can be expected to yield only to partial solution in the local health department or hospital laboratory is a logical outgrowth of this personalized laboratory service to physicians and a result of the closer cooperation among laboratories. It is economically sound that the special work necessary for the identification of organisms isolated in local laboratories should be carried to completion in one central place for the entire area that is served. The physician of today demands of the laboratory a complete study of the causative organism isolated from his patient. It is not feasible for every small laboratory to stock and prepare the special sugars and other reagents and the multiplicity of typing sera necessary for the identification of a variety of bacteria. Further development of this thesis suggests the possibility of reciprocal examinations among the central health department laboratories throughout New England on specialized types of examinations. The idea seems feasible because each of these laboratories has among its personnel persons who are recognized as specialists in particular fields. Economically it is sensible to straddle political barriers if better results can be secured at less cost.

Diphtheria—Some laboratories in New England are undoubtedly now being asked by physicians to do typings of diphtheria organisms. A misconception seems to exist in the minds of some physicians that the gravis type of the Klebs-Loeffler bacillus produces a toxin differing from toxins produced by the mitis or intermedius types. Apparently the fact is that the gravis variety of the organism in certain instances produces enough more of the same toxin to cause extremely severe clinical diphtheria. To clear up another common misconception it may be pertinent to state that since the gravis type of *Corynebacterium diphtheriae* is already present in our communities we cannot say in any particular instance that an infection proved in the laboratory to be of the gravis type has been imported from outside of New England or from beyond the borders of the country. In our laboratories we have spent some time making studies of the types of diphtheria organisms—that is, gravis, mitis or intermedius—isolated from the throats of persons suspected of having diphtheria and it is our present opinion that such typing is a refinement that does not have much value except for epidemiolog research. The old and well known virulence tes still the practical method for determining the vasiveness of a strain of the diphtheria organism

Tuberculosis—One striking change from yes year that today's laboratory director notices is insistent demand for cultures of sputum and body fluids and tissues for tubercle bacilli. Cult ing certainly appears worthwhile as a supplement the examination of smears of sputum for at least t reasons. One, by culturing on appropriate me some organisms are found which are not seen smear preparations even after concentration of sputum. Two, it is possible only through c turing to differentiate between tubercle bacilli a non pathogenic acid-fast organisms that resemb them. The present culturing procedure has the herent drawback that it requires an interval of thr months, at least as carried on in our laborato before final negative reports are given out. T results of current investigations seem promising f a more rapid method of culturing tubercle bac although there is no real practical advance as y Animal inoculations are still desirable in certa instances; if done routinely they are expensive. the future, animal inoculations for tubercle baci will probably be used only on certain types of spec mens which have been shown to yield results animals but not consistently by culture.

Gonorrhea—Cultures for gonococci are no rather universally being demanded by physicia as a supplement to smear examinations. Particular is there a demand for so-called "delayed culture so that specimens can be examined after they hav been collected and mailed or delivered to a labor tory with a lapse of several hours or a day. Delaye cultures are not entirely satisfactory even und rigidly controlled conditions. That so many diffe ent methods for delayed culturing are being pro posed is in itself almost *prima facie* evidence tha none has proved adequate. A recently demonstrate factor contributing to the well known difficulties o obtaining positive findings in specimens from fe males is the detrimental effect of the low pH of th cervical mucus upon the growth of the Neisseria organism. The estrogenic phase of the menstru cycle now appears to be the only time when tha antagonistic effect will not be noted. In a study tha was recently reported no positive cultures wer obtained between the 22nd and 25th days of th menstrual cycle. This knowledge must be kept i

nd by physicians if they are to use the gonorrhea services of the laboratory intelligently.

Brucellosis—Diagnostic tests for brucellosis are entirely new within the last 25 years. This disease in the New England area has equaled and surpassed typhoid fever in frequency. In addition to the agglutination test performed on patients' serum, both the phagocytic index determination and blood cultures are helpful for diagnosis. Blood cultures made on clotted bloods submitted for agglutination tests and on the excess from specimens intended for opsonocytophagic index have yielded, in our laboratory, about 100 isolations of *Brucella abortus* and 2 of *Brucella suis* since we started our test in July 1944.

Syphilis—Serodiagnostic tests for syphilis are still a major concern of most public health laboratories. There has been no striking change in the serological routine of most laboratories in recent days. Altogether too many different tests that have pretty well stood the test of time are now recognized as standard tests for syphilis. It is desirable that some one test be brought forth under official auspices to do away with the multiplicity of tests now being used to the confusion of too many physicians. The use of penicillin for treatment of syphilis has highlighted the need for quantitative tests. Many physicians are no longer satisfied with the old qualitative procedure for any purpose. The most successful quantitative technic seems to be that performed with serial dilutions of the patient's serum. Cardiolipin antigen, with purified lecithin and cholesterol, although still in the experimental stage, bids fair in the immediate future to add much to the reliability of tests for syphilis; means should be found to ensure its early nation-wide adoption. Delayed dark-field tests are satisfactory for the diagnosis of early syphilis. They should be requested more by physicians than they are at present and they should be suggested more frequently by laboratory directors. Laboratories should offer convenient collection outfits for delayed dark-field tests.

PARASITIC DISEASES

Another trend apparent today but not a decade or two ago is the increasing demand for examinations for diseases caused by animal parasites. The United States Public Health Service has cooperated since the war in the training of persons both in state and local laboratories to carry on parasitic disease examinations; facilities for doing this work should now be available in any territory in New England. In Connecticut there has been more increase in laboratory examinations positive for amebiasis and for malaria than for others of these diseases.

Trichinosis—In the past trichinosis has not been too easy to confirm by laboratory means. There is now a satisfactory serological test but positive results are not obtainable early in the disease. Workers at the University of Rochester[1] have recently shown experimentally that the virus of lymphocytic choriomeningitis can be carried by trichina larvae from one host to another. Interesting possibilities are suggested by this research study.

Other Parasitic Diseases—Other serological tests for parasitic diseases deserve mention. Complement-fixation for amebiasis will doubtless become a practical laboratory procedure of the future. The test is carried on using a special technic with an antigen made from a culture of the amebae. So far in Connecticut we have found it desirable to send specimens for this test to the Division of Tropical Diseases at the National Institute of Health at Bethesda. The National Institute is always most cooperative with the directors of state laboratories and its services at the moment are particularly valuable for serological tests for several parasitic diseases, not only amebiasis but also *leishmaniasis*, *schistosomiasis*, *filariasis*, *trichinosis* and *echinococcosis*.

Malaria—To date, to judge from Connecticut experience, the war has not brought to us in New England the great variety of tropical or rare diseases that some persons felt we must be prepared to diagnose. There has been a distinct increase in examinations for malaria, most of which have proved to be of the vivax type. Presumably the plasmodium causing the vivax malaria is more resistant to the atabrine suppressive treatment used by the armed forces than are the plasmodia responsible for the other varieties. Anopheles mosquitoes exist in certain areas in New England. Possibly with the return of persons harboring the malarial parasite we are establishing conditions productive of malaria unless these persons are discovered and properly controlled.

Enterobiasis—Requests are becoming more frequent for examination of anal swabbings for pinworms. The preferred technic is the examination of specimens collected on a swab made with a special type of cellophane attached over the end of a glass rod. Swabbings in the morning are more

satisfactory for detecting *Enterobius* than are stool specimens because during the night the eggs are deposited by the gravid female actually outside the anus of the human host.

VIRUS AND RICKETTSIAL INFECTIONS

The public health laboratory of the future will have to deal increasingly with the diagnosis of virus and rickettsial diseases. The laboratory that fails to prepare for this will be derelict in its duty to the territory it serves. The demand may come earlier to some of the larger laboratories but—as the great variety of laboratory procedures applicable to these two groups of diseases become more and more practicable for routine use—I predict that before too many years have elapsed virus and rickettsial diseases will be the concern of many public health laboratories large and small. It is not as generally realized by physicians as it should be that most virus disease laboratory diagnoses are really diagnoses in retrospect since it is necessary in many instances to examine a specimen taken in the convalescent stage for comparison with the one secured at the acute stage of the infection. Nonetheless, for epidemiological and related purposes the results of virus disease laboratory work even today have real practical value.

Rickettsial Fevers—Complement fixation for the typhus fevers and for Rocky Mountain spotted fever using egg culture antigens today are practicable procedures. Some of the commercial vaccines are satisfactory to use as antigens in these tests for typhus fever. This diagnostic procedure will also be useful in the newly described rickettsial infection that appeared recently in New York State and that goes under the name of rickettsial pox.

Lymphogranuloma Venereum—Complement fixation for lymphogranuloma venereum is not only a useful procedure in aiding in the difficult diagnosis of that infectious disease but peculiarly enough the complement fixation test for lymphogranuloma venereum is applicable to the diagnosis of psittacosis, ornithosis and certain forms of pneumonitis. That is because the viruses in the psittacine group are so closely related that group reactions occur with a lymphogranuloma venereum antigen. In using the results of these tests it must be kept in mind, however, that false reactions occur in cases of cirrhosis of the liver and in certain other conditions.

Influenza—The chicken red cell agglutinin inhibition test is useful in the diagnosis of influenza and in the differentiation of type A influenza fro type B.

Mumps Virus—The complement fixation test f mumps virus is a useful procedure. In the army was found that about 15 per cent of the encephalit encountered was due to mumps virus which man fested itself in atypical form. While that percentag may not apply under our civilian conditions in Ne England, the test has been found worthwhile t prove that some cases of encephalitis are caused b the virus of mumps. In our Connecticut experienc this test has been used to establish a definite diag nosis of mumps on some cases originally thought t be atypical or abortive poliomyelitis.

Virus Pneumonia—The cold agglutination test fo virus pneumonia is a procedure of some value. Thi is an agglutination test of the patient's serum at ic box temperature with Group O blood cells.

Poliomyelitis—To date, unfortunately, no usefu diagnostic test for poliomyelitis has been devised Work on the transmission of poliomyelitis virus t small laboratory animals from stools and othe materials is still in the experimental stage.

Rabies—In the diagnosis of rabies there is nothing new or exceptional that has not been known fo some years. Because of the experience of other state along the Atlantic seaboard, a note of caution should be sounded to the public to watch out for rabies in wild animals, particularly foxes. In Connecticut last year a positive diagnosis of rabies was made on a fox which had been running wild in the Litchfield hills.

A PICTURE OF THE FUTURE

The developments in public health laboratory work over the last quarter of a century have been presented at considerable length. The trends that have been discussed give a glimpse of the picture of the immediate future. That picture is far from complete unless we include in it some of the newer developments that begin to show themselves here or there. Some health department laboratories are now going far beyond what was considered to be public health laboratory work twenty-five years ago in undertaking tests for Rh factor; blood groupings; programs for processing and distributing human blood, plasma and blood derivatives; tests by the Papanicolaou technic for diagnosis of uterine cancer; pathological examinations; toxicology; and many other laboratory tests. The field is broadening rapidly. We must be progressive yet we should

beware of tangential activities until certain of their worth.

Perhaps the light that shines brightest on the laboratory picture of the future is the intense desire on the part of laboratory directors and laboratory workers to bring about improvement in laboratory work and to promote uniformity of accomplishment among laboratories. The efforts of the committees on standard methods of the American Public Health Association laid the groundwork for this accomplishment. Much discussion on a national level in the Conference of State and Provincial Public Health Laboratory Directors and by committees advisory to the United States Public Health Service has resulted in careful evaluations now well established for appraising the accuracy of certain phases of the work of all the state laboratories. A number of state laboratory directors have been instrumental in carrying on evaluation studies and in setting up procedures whereby check specimens are submitted unannounced to approved or registered laboratories within their states. Massachusetts has not only been a pioneer in this work but has set excellent standards that the rest of us can pattern after. As soon as possible these evaluations must be extended to all the activities of all public health laboratories because a great need has been shown by the studies thus far carried on. In some instances the results of appraisals of certain procedures have shown the performance of routine tests in hospital and health department laboratories to be so inaccurate that the persons sponsoring the evaluations on the advice of advisory committees of physicians have felt it unwise to give publicity to the findings for fear of weakening the confidence of physicians in the laboratories they use daily for examination of specimens.

With the present rapid turnover of personnel, with the almost complete unavailability of trained and experienced laboratory workers, with salaries about half what these same men and women can obtain if they go into other lines of work there is something wrong with the public health laboratory picture—something that cannot be corrected by the individual laboratory director. The picture for the future can be made bright only by the use of every possible available means—and the evaluation study and research methodology are among the tools readiest at hand. The interest and cooperation of state commissioners of health, health officers, physicians, and all persons influential in public health must be kept very much alive if a serious condition is to be remedied. The picture at the moment is blurred by the increasing demand for economy in the operation of federal, state and local governments. With reduced expenditures for public health work laboratory activities will be likely to cease growing or to suffer curtailment and it will be all too easy a means of lowering costs to eliminate as frills these checks on accuracy of work. Laboratory directors must acquaint those who handle the purse strings not only with the demands from physicians for new technics but also with the need for accuracy in laboratory tests and with the dangers of compromising on poor or mediocre work in the laboratory or on inadequately trained personnel. Otherwise these many developments which research has brought to the point where they can brighten the picture of the future cannot highlight it as they must if the laboratory is to remain the firm foundation stone on which rests solidly so much of the imposing superstructure of the public health.

REFERENCE

1. The transmission of the virus of lymphocytic choriomeningitis by *trichinella spiralis*. Syverton, J. T., O. R. McCoy and J. Koomen, Jr., Jour. Exp. Med., 85, 6, (June) 1947.

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EDITORIALS

A Corporate Society

The announcement by one of the large labor unions of a plan to establish a medical center to give care to its members is significant because it gives concrete evidence of the growing desire on the part of workers to remedy one of the problems of insecurity which many face. The fear of prolonged or catastrophic illness creates anxiety, just as the fear of loss of work and of the insecurity of old age. Such fear is threatening to personal integrity and engenders loss of self-respect. It is commendable that such groups should seek to remedy such problems within the structure of their own organization, in their own hands, and that they have the wisdom to foresee the hazards of attempts at remedy under government control. The movement, which seeks to interest both Labor and Management, shows signs of great potentiality, for other large organizations are rapidly becoming similarly minded. Medicine should find in this type of planning a sympathetic interest, for it alone can furnish medical care. It seems apparent that many of the differences which exist between Labor and Management today are those which require adjustment along the lines of social welfare. It is in this field that prepayment medical insurance should play an important part. For such insurance to be adequate and satisfactory there is no question that it should be under the control of the medical profession. Furthermore, it must be of such comprehension in coverage and soundness in financial structure as to be an attractive investment. This is a form of "socialized" medicine in which Medicine can take a proper part with honor and without loss of integrity. It should be recognized as an opportunity for Medicine to cooperate with Labor and Management toward the highest good, which is the public good. Medicine, like Labor and Management, is not outside of human life but within it. Whether we like it or not we have to realize that we are living in a corporate age and, difficult as it often appears, we are forced to the conclusion that many of the ideas of human relationships which we have always considered as inherent and stable in our civilization are no longer tenable and must be abandoned. The Sage of Concord wrote: "Society is everywhere in conspiracy against its members," but he also wrote in the same essay: "accept the place the divine Providence has found for you, the Society of your contemporaries, the connection of events."

Challenge and Response

By Raymond B. Fosdick

All centuries are dangerous, said Professor Whitehead; and he added: "It is the business of the future to be dangerous." This was written in 1925, and certainly there can be no question of the accuracy of the prognosis as it applies to our generation. The challenge of today's crisis is the most commanding which Western society has ever faced. We have always known that knowledge was a perilous possession, because it could equally well work in the wrong direction; but the knowledge that has been placed in the hands of this age is so supremely capable of misuse—and misuse could so easily reduce the hopes and monuments of men to drifting dust—that the impact of the challenge finds us confused, uncertain and fearful.

Like all frightened people everywhere and in all ages, our first reaction is physical force, and our instinctive faith is given to military power. Let us grant at once that in this unprecedented crisis a measure of physical force is essential. We do not live in a utopia, and it would be suicidal to act as if we did. Equally suicidal, however, is the assumption that the crisis can be met solely on the level of force, or that mechanisms, power and dollars constitute the essential elements of the solution.

The present is one of the supreme moments of challenge, in which, as Toynbee says, the character of our response determines the chances of survival. The past is littered with the wreckage of nations and empires which tried to meet the crisis of their times by physical means alone. Our response today cannot be confined to this lower level. Unless we can rise to greatness and lift our answers to an intellectual and ethical plane, our fate will be the fate, not only of the nations that preceded us in history, but of all species, whether birds or brontosaurs, which specialized in methods of violence or defensive armor.

One of the difficulties in putting our response on a higher level of human searching is our emphasis here in America on the task of raising the material standards of living. In this ambition we have been incomparably successful; our productive and consuming capacity is greater than that of any other country in the world. But the result is that our principal standards are standards of quantity: we have more of everything than anybody else—automobiles, refrigerators, radios, railroads. Consequently our vision is not so much of a world peopled by wise and honorable men as it is of a world in which "every family has its automobile and every pot its chicken." We have too easily made the assumption that other values would automatically follow our material well-being, that out of our assembly lines and gadgets the good life would spontaneously be born.

One of our leaders recently said that Europe could prosper in the long run only as she adopted what he called the American philosophy of consumption. This uncritical identification of consumption with social value is, of course, not characteristic of this country alone or of this age alone; but the extent of the confusion in America today is disquieting. Although our religion and ethics have long tried to enlighten us, many of us are still only dimly aware that purchasing power is not the measure of a great society, and that wisdom and cultural values are not the inevitable consequences of an increased capacity to consume.

It is, of course, obvious that a solid material foundation is an essential basis for a high civilization; but it is a basis, not a superstructure. Our tendency is to confuse one with the other, to mistake the foundations for the towers and turrets of the new city. There is a spiritual hunger in the world today that is not being satisfied by American exports. "God knows we need food and coal to survive," said a European delegate to Lake Success, "but unless America can take the lead in providing a vital faith, in giving us a song that mankind can sing, all her exports will merely postpone the day of reckoning, and the world will die anyway."

Another aspect of the difficulty which we face in placing on a higher level our response to the challenge of our time, is our superstitious reverence for the physical sciences. They have become sacrosanct—the dispensers of the gifts of life. The doctrine that "civilization can be bred to greatness and splendor by science" is widely accepted. Even our universities have succumbed to this twentieth century worship of methods which give mastery in the physical world. In contrast with the money available for the humanities and the social studies, far greater sums are today being allocated to the physical sciences by our educational institutions than ever before. From government and business, as well as from college budgets, money in increasing

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amounts is being poured into the teaching of chemistry and physics. "This is the Century of Science," one characteristic college announcement proclaims, "and we must orient our students to the prevailing interest of their time." A prominent eastern university reports its enlarging plans with these words: "In the face of the increasing impact of science on our society it is widely agreed that an essential aim of general education is to impart to the university undergraduate an appreciation of the methods of the sciences." Of course, a decent obeisance is always made in the direction of the humanities and the social studies. The fact remains, however, that in terms of endowment, research facilities and teaching staffs, these studies are far outdistanced by the physical sciences, and the gap is growing wider.

But the gap should be closed rather than widened. We cannot escape the obligation, in this scientific age, to comprehend science; but in the supreme question which faces our generation, physics and chemistry and engineering have no answers for us. They are ethically neutral. They are preoccupied with physical matter. They can give us more horsepower; only the naive, however, will claim that horsepower can develop within itself the means by which our runaway technologies can be brought under control. They can help more men to better health and longer life; but they have little relationship to the problem of discovering a new set of human purposes, or to the art of human relations, or to the winning of social and moral wisdom, upon which peace and successful government depend.

It is scarcely necessary to acknowledge our vast indebtedness to science in giving us the methods and patterns of research in human relationships. Every contribution of science to the problems of society is to be welcomed. But the enlightenment of science is bringing with it a tendency to reject the limitations of science. To expect that exact measurement and exhaustive definition will relieve us of the necessity of ethical inquiry, or that the meaning and values of human life will somehow or other crystallize as physics crystallized around the concepts of mass and energy, is a form of superstition as deadly as any we have known.

The issues of our time and of human destiny will be determined, not at the physical, but at the ethical and social level. Material power and dollars and military ascendancy may preserve us temporarily; but the dynamic tensions of our society can be relieved only by moral and social wisdom, and that kind of wisdom cannot be precipitated in a test tube nor can it be won by the brilliant processes nuclear physics.

In the same essay which was quoted at the begi ning of this section, Professor Whitehead went to say: 'It must be admitted that there is a degr of instability which is inconsistent with civilizatio But on the whole, the great ages have been t unstable ages." This is the ray of hope that lighte the darkness of the present hour. It is not in tim of security that men build a Chartres Cathedral write a *Hamlet* or push their boats across an u known ocean to discover a new continent. Odd enough these achievements occur in years of i stability.

Danger and hazard mark our age today. But Professor Whitehead's phrase, it can be a great ag like other ages that have been born out of fear an challenge. Its greatness, however, if achieved, wi consist in its search for an enlightened humanis and for rational and ethical values that will ris above our time as the spires of Chartres rose abov the twelfth century.

Why Patients Don't Pay

Eighty-nine per cent of the delinquent account in the average physician's files are the fault of th physician. This is the statement which comes afte a recent survey by the Bureau of Medical Economic of Alemeda County, California. The survey indi cates remedial measures and emphasizes the need fo a more intensive study if medicine is to maintai the present system of practice. An analysis of th reasons for such broken physician-patient relation in these delinquent accounts shows:

1. Poor business methods in doctor's office (No billing; insufficient information to trace "skips"; statements not itemized; no collection follow-up in doctor's office)	30.23%
2. Patient not informed (Failure of doctor to make clear financial arrangement with patient prior to treatment or sending bill; patient not informed of other costs, lab., x-ray, etc.)	21.00%
3. Adjustable economic difficulties (Out of work; other illness expense; medical indigency)	19.00%
4. "Dead-beats"	10.99%
5. Negligent; slow pay	9.61%
6. Bonafide dissatisfaction with treatment	3.40%
7. Someone else owes bill	2.04%
8. Excessive fee	2.00%
9. Other	1.73%
	100.00%

According to the report published in the *Bulletin of the Alameda County Medical Association*, May 1948, the recommendations are:

The public relations of medicine, and the incomes of doctors, will be improved if doctors will:

1. Establish a clear financial understanding with patients prior to treatment, or at least prior to sending a bill, if the charge for any service is to be above $10. This understanding includes: (a) explanation of both the probable and possible extent of the treatment and the reasons for the cost, if these things would not be readily apparent to *every* layman; (b) determination of the patient's ability to pay, based not only upon his agreement to the amount of the fee, but upon the doctor's understanding of the patient's actual *ability* to pay (patients agree to anything when they are ill!); (c) charge no more than the patient is well able to pay, and agree upon the *specific* method of payment, even to the dates and the amounts that are to be paid on those dates; (d) determine who is the responsible party—who is legally obligated to pay for the services—and have this understanding with him and no other. These suggestions are not in any way commercialistic. To the contrary, it is unfair (if not actually dishonest) to place a patient under a financial obligation to you about which he does not have full knowledge.

2. Report each new patient who seeks medical credit to the Bureau of Medical Economics, so that chronic delinquents may be recognized and educated to good paying habits by the bureau.

3. Inform the patient of his responsibility to pay for other services: laboratory, consultant, assistant, x-ray, anesthesia, hospital, etc.

4. Bill regularly, and itemize all statements.

5. Contact the bureau to learn a good collection follow-up system for each particular office.

6. Get full information regarding patient during the initial interview: full name, full name of responsible party, where employed, kind of work, address, telephone number, insurance coverage, name of wife or husband. The bureau has new patient "Registration Cards" that accomplish this painlessly.

7. Take time to explain the diagnosis and the treatment and avoid overly optimistic prognoses.

8. Develop and use consultants in office management and public relations for the offices and practices of individual doctors.

Doctors whose collections previously ranged from as low as 65 per cent to as high at 90 per cent, who have followed these recommendations of the Bureau of Medical Economics, have increased their collections to as much as 98 per cent. What is more important, they have increased patient satisfaction with the economics of medicine proportionately, and have immeasurably increased their own satisfaction in the practice of their profession.

Death Rates for 1947

The death rate from all causes among U. S. life insurance policyholders reached a new low in 1947 at 737.9 per 100,000, with declines shown for practically all causes of death including heart disease and cancer, the Life Insurance Association of America reports. The 737.9 rate compares with 773.1 in 1946 and 763.9 in 1942, the previous lowest rate. These results are indicated by the experience of companies representing 73 per cent of the ordinary and industrial life insurance policies in force in all U. S. companies.

Heart diseases of all kinds constituted the leading cause of death among policyholders last year. Nearly half of all the deaths included in the survey were attributed to heart diseases, cerebral hemorrhage and nephritis which together make up the principal diseases in the group called cardiovascular-renal diseases. The combined death rate from these causes in 1947 was 361.5 per 100,000 policyholders. This was about 1 per cent lower than the corresponding rate in the previous year, due chiefly to improvement among industrial policyholders. If the 1947 rate is taken as indicative of experience among all policyholders it may be estimated that approximately 600,000 policies became claims from the principal cardiovascular-renal diseases last year.

Cancer, the second leading cause of policyholder deaths, also declined during 1947, the first drop in several years. The 1947 death rate of 114.8 compares with 116.9 in the previous year and 106.8 in 1942. Cancer deaths terminated an estimated 200,000 life policies last year.

Practically all of the other important death causes showed a lower rate in 1947. The accident death rate among policyholders last year was 45.8 per 100,000 compared with 49.3 in 1946 and 53.3 in 1942. The death rate from tuberculosis declined to a new low of 26.1, nearly one-quarter lower than that for 1942.

The death rates differ between ordinary and industrial life insurance policyholders. In almost all cases, the death rate is higher for the industrial life insurance policyholders than for ordinary insurance policyholders. In the cases of tuberculosis and diabetes, the industrial rate is strikingly higher.

From the Institute for Life Insurance

Medical Care and the Cost of Living

Physicians are interested to know whether the general cost of living has gone up faster or slower than the professional charges by physicians such as an office call. Recently compilations for 1947 were assembled by the Bureau of Medical Economic Research of Chicago using data gathered from 34 large cities by the U. S. Bureau of Labor Statistics. The general answer shows that the cost of living for 1947 was higher than the index of any reported medical item. Although the sampling in 34 large cities does not reflect price changes in all places where physicians practice, it does give a picture of what the general trend of prices the American people are paying for their medical care. In a recent release the Director, Dr. F. G. Dickinson states:

"The inescapable conclusion is that the cost of these important items of medical care have risen since 1940, but with the exception of hospital items not as rapidly as the general cost of living. This conclusion reinforces and substantiates the conclusions in my study of the costs of medical care. (*Is Medical Care Expensive?* Bureau of Medical Economic Research, American Medical Association, 1947, twelve pages—breakdowns for 1946 appear in overprinted copies only.) In this earlier study the conclusions were that medical care items as a whole cost the American people $5,600,000,000 in 1946 but that only 3.9 per cent of total personal consumer expenditures of the American people were spent for these medical care items; this compared with 4.3 per cent in 1940. More particularly, in 1946 the amounts spent for physicians' services and hospitals were 1.0 per cent and 0.6 per cent of total personal consumer expenditures in that year. Hence the general conclusion was that the American people were spending a smaller percentage of the total consumer budget for medical care as a whole and for physicians and hospitals as components thereof. It was also stated that in 1946 physicians received only 26 per cent of all the dollars spent for medical care as compared with 31 per cent in the base period, 1935-39, and 35 per cent in 1929, the first year for which the data were gathered and published by t U. S. Department of Commerce. On the other ha it was shown that the amount spent for drugs 1946 had risen to 24 per cent of all dollars spent medical care as compared with only 21 per cent the base period, 1935-39, and 20 per cent in 19 Thus the story of the wonder drugs is written i the recent history of medical economics. On t other hand, the percentages for hospitals were 17, and 13 respectively; for dentists the percenta were 13, 13, and 16. It was also stated in my earl study that the people are getting more for th money. They get well quicker, they live and ea longer. The type of medical care given in 19 differs as much from the type given in 1929 as 1946 passenger automobile differs from a 19 model. Life expectancy at birth rose from 59 yea in 1929 to 67 years in 1947.

"Whether one examines the record of total e penditures of the American people for medical ca or the prices of significant items during recent yea he comes to the general conclusion that the Amer can people have been fortunate in that the costs keeping well have not risen as rapidly as the co of living. This information and these conclusio should be of great importance to all citizens who a concerned with the general problem of trying t improve the medical care of the American people.

Womens' Medical Society Disbands

The Women's Medical Society of Connecticu was formally disbanded at a meeting held at th Fairfield Inn, Fairefild, on April 29.

Action followed a talk by Elizabeth C. Wells M.D., president, Hartford, in which she explaine that members of the organization felt it was n longer serving a useful purpose and that the inter ests of women in Connecticut medicine could bes be served by active participation in the affairs o the State Medical Society.

Dr. Wells also said that reluctance of members o the organization to affiliate with the American Women's Medical Association further limited th usefulness of the organization.

Members voted to contribute funds remaining i the treasury to the Women's Medical College o Philadelphia as a memorial to Dr. Kate Campbel Hurd-Mead.

PROGRESS IN CLINICAL MEDICINE

MEDICAL PROGRESS IN THE TREATMENT OF BLEEDING ULCERS

JOHN B. WELLS, M.D., *Hartford*

ALTHOUGH hemorrhage from a peptic ulcer is not at all rare, there is no generally accepted form of treatment at the present time. To add further to the confusion, there is no uniformity in the statistics dealing with the mortality of this disease. Bockus[1] has enumerated some forty different mortality rates collected from reputable sources in this country and abroad and noted that they vary from 1.3 per cent to 24.1 per cent. The discrepancy probably can be explained by the selection of cases in a disease that varies tremendously. Accurate diagnosis is difficult to make. We must, therefore, accept the fact that statistics are unreliable in the correlation of the methods of treatment in the bleeding peptic ulcer.

It is probably true that at one time or another, all peptic ulcers bleed, although the extent to which this bleeding takes place is variable. It may manifest itself in gross hemorrhage, hematemesis,[2] and melena, or it may be restricted to microscopic weeping of red cells in the ulcerated area demonstrable only in occult blood determination of the stools. The amount required to make the stool positive for blood is not constant and depends to a great extent upon the activity of digestion, speed of passage in the intestine,[3] and the method which is used for its determination. That there is a difference in the individual digestive ability has been demonstrated by cases in which gross hemorrhage has been observed gastroscopically followed by repeatedly negative stools for occult blood. It has long been noted that certain individual's stools will be positive for blood except when on a strict meat-free diet. However, it has been shown that[4,5,6] blood to the extent of 1½ gms. dried, or 15 cc of whole blood is sufficient to cause the stool to become positive in a vast majority of normal, healthy individuals. The specific tests for blood in the stool are all unsatisfactory and there is a dearth of investigative work available in this field at the present time. The most reliable test for the presence of occult blood in the author's opinion is the old-fashioned guaiac test of the etherial extract of the acidified stool. (Levinson and MacFate).

When confronted with a situation that is as imposing as hemorrhage from a peptic ulcer, there are a few fundamental considerations that must be remembered. There is the background of the patient as well as the immediate situation. Anyone who is not impressed by the emotional makeup of the ulcer patient is, indeed, most unobserving. It is almost by definition that he is of a nervous temperament. Within him surges a sea of turmoil which has no outlet and consequently has no end. Add to this, the upsetting affect of vomiting large amounts of blood with massive black bowel movements. Further excitement is accumulated by friends and relatives. The physician who attends the patient in this situation must be, at his very best, the master of the art of reassurance. In voice, action and manner, he must reflect composure and calm. There are other forms of sedation which should be used when fear and excitement prevail. The oldest and most honored sedative for hemorrhage of any sort is morphia. It still is, probably the most effective in spite of the condemnation that has been cast upon it of late, due to the nausea it produces in a certain number of individuals. Morphine, when given intravenously, is more effective, acts faster, and, in state of shock, is cast directly into the circulation instead of pooling in the periphery where there is extensive constriction of the vessels. It also appears to be as innocuous as the simplest intravenous preparation when administered slowly. Other forms of sedation, such as demerol and the barbiturates, appear to be generally preferred at the present time. Their main fault is that they are not used in large enough quantities and are given too infrequently to produce the desired effect.

There has been a considerable amount of discussion and disagreement concerning the physiological results of shock as well as the method of its treatment in respect to hemorrhage from peptic ulcers. It is rather well accepted that hyperazotemia exists as a result of absorption of the breakdown products of blood. This azotemia is greater than any that occurs from the renal ischemia resulting from the

drop in blood pressure. The experimental evidence of the action of blood loss on motility of the intestine is contradictory. Wakim[7] and Van Lieve[8] report entirely conflicting evidence in regard to motility of the intestine following the exsanguenation of dogs.

In view of the recent advances in the treatment of shock, it seems apparent that there are greater dangers to be encountered in gastrointestinal hemorrhage by the maintenance of the blood pressure at low levels, than might occur from the dislodgment of a blood clot in the bleeding vessel. The damage that can occur as a result of even mild shock, especially in the older age group who have arteriosclerotic changes and renal damage, is severe. It is these individuals who show the least ability to constrict an offending vessel. The maintenance of the body physiology by means of adequate replacement therapy is of greater value than any momentary increase in intravascular pressure and it can be continued as long as there is need for it. Furthermore, the clotting advantages of the blood can best be enhanced by increasing its viscosity rather than by diluting it. In this respect, there is nothing as good to replace blood as blood itself.[9] It has been pointed out that plasma is more readily available and can be used without danger of a severe hemolytic reaction. However, that danger is now more than offset by the chance aquisition of serum hepatitis in the use of pooled plasma. A study of hypertension and its relation to intestinal bleeding has been made by Rafsky[10] on 476 cases in which that author feels that the hypertensive individual has as good a prognosis, as far as the hemorrhage is concerned, as the non hypertensive. In his statistics the hypertensive individual, on the basis of arteriosclerosis, did not show a greater mortality than the non hypertensive. Those hypertensives below the age of 50 years did show a slight increase in mortality on the basis of complicating disease, rather than on the basis of elevated blood pressure alone.

The best method for the detection of shock is through careful observation of the individual. The most reliable sign of internal bleeding is reflected in the blood pressure and pulse of the individual with the noted exception of the aged in whom an advanced state of shock can exist without appreciable change in the radial pulse. The determination of the hematocrit is of value only in the later stages of intestinal hemorrhage in which there has been dilution of the blood plasma from the reserve of interstitial fluid, in an attempt to restore the circulating volume. This does not mean that rapid transfusi or replacement of blood volume by large amou of intravenous fluid is to be condoned in th individuals. The plea is rather to replace selective inasmuch as possible, the lost products in exactly t same proportions as had existed previously, therel protecting the patient from shock and its resulta sequelae.

Meulengracht was not the first to advocate t abandonment of the starvation diet in the treatme of gastrointestinal hemorrhage. Lenhartz[11] expe mented with feeding the patients milk and eggs soon as the gross hemorrhage had stopped, and 1906 reported 104 cases so treated, with a mortali of 2.1 per cent. Meulengracht[12] commenced h series in 1931. The diet prescribed by him permitt four feedings daily and was termed by the sponso "free feeding." The patients were allowed as muc as they wished of such items as meat, fish, brea butter, vegetables, eggs, tea and cocoa and he e couraged them to eat as much as they were abl Meulengracht made no particular claim for th specific diet, stating definitely that any form bland, non irritating diet based on culinary custon and availability was just as satisfactory providin it was given in sufficient quantity.

Others have not been as successful in reproducin the low mortality figures of 1.5 per cent nor hav they all been able to make use of this "free feed ing."[13] Most of the observers in this country agre that the majority of patients with severe hemorrhag are far too ill to avail themselves of this liberal in take. The patients studied by Meulengracht wer those in a municipal hospital in Copenhagen wher admissions for symptoms of melena may or may no have denoted severe disease, as only about one-thir had x-ray evidence of ulcerations. That they wer not as sick as many of the patients of other series may be true. At least, it has been found most difficul to make our patients accept nourishment as de scribed. They are usually too ill, or possibly th Dane is of more sturdy stock than we. The basi reasons for which he use the "free feeding" diet however, remain valid.

American and British authors find that the use of a modified Meulengracht diet, which consists i more frequent (hourly) feedings of milk, eggs an gelatin is better suited to our abilities and appetites It is handled better and has all the advantages which are claimed for the heavier meals. Lately there ha been an increased tendency to use the more highly purified products[15] which contain protein hydro-

lates, amino acids of varying proportions and which have been advocated as being more easily assimilated. The advantages which these highly simplified products maintain over the other less expensive and more easily available forms of protein, such as milk, eggs, etc., probably do not warrant their use.

The reasons that the bleeding ulcer patient is now fed, instead of starved as he was a few years ago, are several. First, it is well acknowledged now that the hemorrhage is only a complication of a disease which is primarily peptic ulcer, and the treatment of peptic ulcer is not starvation. The empty stomach has repeatedly been demonstrated to be highly hypotile with hunger contractions and spasm.[16] The adherents to the starvation principle have formerly feared the dislodgment of the clot by the mechanics of digestion hoping that restraint would give time for the plug to become adherent in the offending vessel. It has been demonstrated fairly satisfactorily now that this is not necessary, in fact, it may be harmful. The food taken into the stomach acts as a dilutant of the acid and is probably more effective in clot formation than any mechanical interference which it might cause. It is unbuffered gastric acid that activates the pepsin which, in turn, retards the formation of the clot or actually digests it. Probably the most important reason for administration of the frequent feeding diets in bleeding ulcer patients is the prevention of the "exhaustio virium." By means of the diet the body electrolyte can be maintained and the plasma proteins can be replenished. It is becoming more obvious that the body chemistry must be kept functional, that the metabolism must be maintained, and the depletion of vital stores (strength) be avoided.

It has been pointed out that the statistics which deal with bleeding ulcers are notoriously variable and this applies to those that are published on the mortality of surgical intervention as well. The surgical approach to hemostasis is filled with dangers. The location of the bleeding point is a tremendous task as is demonstrated by the frequent failure to locate the source of bleeding even at autopsy. Likewise, the surgeon is dealing, at best, with an individual who is chemically out of balance, who has suffered from a loss of plasma protein and oxygenating power, and who is, has been, or will be approaching a state of shock. Wangansteen[17] advocates early operation of all bleeding ulcers in whom an accurate diagnosis and localization of the bleeding can be determined. He gives a relatively low mortality rate of 10 per cent to 13 per cent in his series, which is slightly higher than the general overall mortality rate for the entire group treated without surgery. Clarke[14] reserves his surgery for the patients who are in the older age group and who have had massive hemorrhage but he advises the postponement of surgery until the bleeding has been controlled and the patient's condition is at its very best. Wilkinson,[18] analyzing the cases at the Lahey Clinic, feels that there is justification for the medical management of bleeding peptic ulcers even following the recurrence of massive hemorrhage, inasmuch as in their series of cases, 78 per cent did not have a recurrence of their hematemesis. However, he feels that two or more hemorrhages indicates that operative intervention and radical resection of the stomach following the medical control of the acute process gives the best opportunity for satisfactory control. Gray,[19] at the Mayo Clinic, suggests an exclusion operation for patients who could not survive a more radical procedure as a possibility for aged and debilitated cases. Heuer[20] states that if surgery is to be done at all, it should be performed within 24 to 48 hours of the onset of bleeding. Meyer[21] of Chicago, gives some interesting figures which claim a mortality rate of 7.2 per cent for all patients with hematemesis irrespective of the severity or age. Those under 45 years showed a mortality of 0 per cent whereas for those over 45 it was 21 per cent. The group that received surgery had a mortality rate of 30 per cent for those under 45 and 42.8 per cent for those that were older.

The conclusion that is reached after noting all the evidence is that the present trend of surgery in the bleeding ulcer from the upper intestinal tract is one of definite conservatism. It might be said that hemorrhage itself is almost a contra-indication to surgery, that radical resection of the stomach has a definite place in the control of subsequent or frequent severe hemorrhage and that the best results are obtained when the patient is explored, if he must be, well after recovery from the hemorrhage.

Another subject that has interested many in the treatment of bleeding peptic ulcer is the relative value of antacid therapy. The antacids fall into three main groups including the soluble salts, the colloidal aluminum hydroxides and magnesium trisilicate. Each has its advantages and some disadvantages but it is not within the scope of this article to discuss their individual characteristics. Their use in

the treatment of hemorrhage are of minor importance in the cases which are fed frequently, inasmuch as the food dilutes and neutralizes the gastric acidity sufficiently in most instances. It must be remembered that nocturnal gastric acidity frequently produces symptoms[22] and should be neutralized either with food or antacids. Bockus[1] feels that the antispasmodic drugs, such as belladonna and atropine, in one form or another, are preferable to the antacids in decreasing the gastric motility and secretory effort. Woldman[23] feels that constant intragastric instilation of colloidal aluminum hyroxide produces a constant achlorhydria which he feels is very desirable. Soper[24] advocates the treatment of bleeding peptic ulcer by means of constant suction of the gastric secretions by means of a soft rubber catheter. Both have persuasive reasons for their treatment in this manner but it is doubtful that either form of treatment has any particular superiority unless there are unusual symptoms of pain or signs of true obstruction.

For many years there has been a reluctance to submit patients who have had a history of bleeding from a peptic ulcer to the usual roentgen procedures to demonstrate the ulcerated crater. The coarseness of the barium meal and the manipulation during the fluoroscopy has been condemned for a long time as dangerous. For this reason postponement of x-ray examination has made the demonstration of the ulceration impossible. A. O. Hampton[25] studied this problem and came to the conclusion that under certain conditions the examination of the patient can be safely performed as soon as three days after hemorrhage. Hampton's work was originally made on a large group of cases at the Massachusetts General Hospital and his impressions have largely been confirmed by most roentgenologists.

SUMMARY

The treatment of the bleeding peptic ulcer has shown the following trends:

(1) Vigorous treatment for shock by supportive measures as long as it is present.

(2) Frequent feeding of the patient with a liquid or semi-solid high protein diet for the purpose of diluting the stomach acidity and maintaining the nutrition of the individual.

(3) Surgery in the acute stage of hemorrhage is to be avoided in the vast majority of cases.

(4) Early roentgen examination of the G. I. tract can be safely accomplished.

BIBLIOGRAPHY

1. Bockus, H. L.: Gastroenterology, Vol. I, 589, W. Saunders Co., 1946.

2. Jankelson, I. R.: "Massive Hematemesis", Gastroenterology, 5:97, 1945.

3. Kuschen, M., Sorter and Necheles: "Occult Blood Wi Note on Carmen," American Journal Digest Dis., 9:15 1942.

4. Johnson, A. S. and Oliver, E. B.: "Effect of Ingeste Blood on Tests for Occult Blood," Jour., Lab. & Clin. Med 26:727, 1942.

5. Schiff, L. et al.: "Oral Administration of Citrated Bloo in Man," Am. Journal Med. Sc., 203:409, 1942.

6. Kiefer, E. D.: "Detection of Occult Blood in Feces. Am. J. Surgery, 25:530, 1934.

7. Wakim, K. G. and Mason, J. W.: "Effect of Blood Los on Intestinal Motility in Dogs," Gastroenterology, 4:1, 194

8. Van Liere, E. J., Northrup and Stickney: "The Effec of Anemic Anoxia on the Motility of the Small Intestine, Am. J. Physiol. 142:260, 1944.

9. Radloff, F. F.: "Observations of 548 Cases of Pepti Ulcer," Gastroenterology, 8:343, 1947.

10. Rafsky, M. A. and Weingarten, M.: "The Effect o Hypertension on the Prognosis of Bleeding Peptic Ulcer," Gastroenterology, 11:93, 1944.

11. Editorial, Gastroenterology, 6:4, April, 1946.

12. Meulengracht, E.: Fifteen Years Experience with Fre Feeding of Patients with Bleeding Ulcers," Arch. Int. Med. 80:697, 1947.

13. Miller, T. G.: "Medical Treatment of Peptic Ulcers," Med. Clin. N. Am. 403, March, 1944.

14. Clarke, W. E.: "The Significance and Management of Bleeding from the Upper Gastrointestinal Tract," Southern Med. J., 38:24, 1945.

15. Tui, C. et al.: "Hyperalimentation Treatment of the Peptic Ulcer with Amino Acids," Gastroenterology, 5:1, July, 1945.

16. Jordan, S. M.: "Peptic Ulcer, a Diagnostic and Therapeutic Problem," Gastroenterology, 9:237, 1947.

17. Wangansteen, O. H.: "Surgeon's Role in Management of Peptic Ulcer," New Eng. J. Med. 236:191, 1947.

18. Wilkinson, S. A., Tracey, M. L., Jordan, S. M., Kiefer: J.A.M.A. 103:2004, 1934.

19. Gray, H. K. and Sharpe, W. S.: "Exclusion Operation in Peptic Ulcer," Ann. Surg., 121:840, 1945.

20. Heuer, G. J.: "Treatment of Peptic Ulcer," 1944.

21. Meyer, J.: Sorter and Nicheles, "Medical and Surgical Treatment of Hemorrhage from Peptic Ulcers," J.A.M.A., 120:11, 1942.

22. Sandweiss, D. J.: "Nocturnal Gastric Secretions," J.A.M.A., 130:5-258, 1946.

23. Woldman, E. E., and Rowland, V. C.: "A New Technique for the Control of Acidity in Peptic Ulcer," Am. Jour. Digest. Dis., 2:733, 1936.

24. Soper, H. W.: "Clinical Gastroenterology," pp. 91, S. V. Mosby Co., St. Louis, 1939.

25. Hampton, A. O., Amer. J. of Roent. and Rad. Therapy, 38:565-570, 1937.

THE PRESIDENT'S PAGE

Your President has had the privilege in the past month of carrying the greetings of the Connecticut State Medical Society to the Hawaii Territorial Medical Association at its annual meeting in Honolulu and of partaking in a program of graduate education of the Honolulu County Medical Society lasting some two weeks. This provided an excellent opportunity to meet many members of the medical profession in the "Islands," and to see at first hand what they are doing individually and as an organized profession.

As physicians and surgeons engaged in practice and bearing heavy responsibilities at a considerable distance from the "mainland," they rank well up with any similar group with which I am acquainted. Not only are they highly competent but well informed and conversant with current advances; indeed, they set a standard which can be well emulated by many, and rarely if at all surpassed.

Organized medicine there has many problems, perhaps no greater or more numerous than our own, but certainly more imperative. While the population is about one-fourth that of Connecticut, and the ratio of physicians to this approximately the same, it is a "melting pot" of the occidental and the oriental with a culture and economy which are rapidly changing to which no one can escape making adjustments. There is, however, in this critical period an atmosphere of flexibility and of tolerance which is admirable. The territory of Hawaii is, in fact, an experimental proving ground for the practice of medicine, and the organized profession there is meeting the issues with an alertness and judgment that can well serve as an example to those of us who dwell "in the land of steady habits."

Samuel C. Harvey

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

JAMES G. BURCH
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NEW COMMITTEE ON PREPAID MEDICAL SERVICE

The House of Delegates of the Society, at its annual meeting on April 27, 1948, voted to establish a new Committee on Prepaid Medical Service to consist of one member named by each of the component county associations. This action was in accordance with the following recommendations contained in the supplementary report of the Committee on Prepaid Medical Service presented by Dr. James R. Miller Chairman, at the meeting.

"The committee recommends to the House of Delegates:

"(1) That the present Committee on Prepaid Medical Service be discharged;

"(2) That each county association be requested to name one member of a new state Committee on Prepaid Medical Service and inform the Secretary of the State Society of the appointment before June 1 of this year. These appointments can be made by the county associations in any way they wish, by the president or governing board of the association, or by election at a special meeting of the association;

"(3) That as soon as practical, after June 1, the President of the State Society shall call the appointed members of the committee together in its first business meeting for the purpose of electing a chairman and secretary of the committee and discussion of the committee's objectives; thereafter the committee shall operate on its own initiative and seek such counsel and advice from within and without the state as it deems advisable;

"(4) That the committee may request the Council to call a special meeting of the House of Delegates at any time when the committee has a plan and method of operation prepared for consideration by the delegates;

"(5) That the Council be authorized to make available from the funds of the Society a reasonable sum of money for the ordinary operating expenses of the committee.

"(6) That when a plan has been devised, approved by the House of Delegates, and placed in operation, this committee shall continue as the Society's representatives in its operation, and vacancies on the committee shall be filled by appointment by the county association in which the vacancy has occurred; and the president of the State Society shall at all times be a member of the committee, with privileges equal to all other members of the committee, except he shall not serve as its chairman."

Seven of the county associations have named their representatives on the new committee and the members are:

Fairfield—Joseph H. Howard, Bridgeport.
Hartford—James R. Cullen, Hartford.
Litchfield—Thomas J. Danaher, Torrington.
Middlesex—Norman E. Gissler, Middletown.
New Haven—Walter I. Russell, New Haven.
New London—Henry A. Archambault, Taftville.
Tolland—
Windham—William M. Shepard, Putnam.

The president will call the committee together for organization in the near future.

Expansion of Student Membership Program Planned

Three years ago, this Society became the first in the country to adopt a provision for student membership. Under the by-law covering this classification, any person whose legal or family residence is in the State of Connecticut and who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an approved medical school or any person who is a student in an approved medi-

c school in Connecticut may become a student nber of the Society. Student members are en- t ed to all of the rights and privileges of member- s p in the Society except that they may not hold ice or vote. They are not required to pay dues d they may subscribe to the JOURNAL at a special e of $2.50 a year.

The opportunity to join the Society has been eived with enthusiasm by medical students all er the country and there are currently over 250 dent members. Moreover there has been great erest in this development in other state medical cieties and in the American Medical Association. he value of this plan as a means of acquainting udents with the problems and responsibilities of ganized medicine in Connecticut and in the nation s been generally recognized.

In his annual report to the House of Delegates, e executive secretary recommended the establish- ent of a Committee on Student Members which ould be charged with the responsibility of direct- g this activity and extending the usefulness of ch membership. The House adopted the recom- endation and the Council has appointed a com- ittee comprised of:

David F. Conway, Jr., New Haven, chairman—olumbia College of Physicians and Surgeons 1937.

William J. German, New Haven—Harvard Medi- al School 1926.

Sanford W. Harvey, Middletown—Cornell Medi- al College 1946.

J. David McGaughey, III—Jefferson Medical ollege 1944.

Robert P. Noble, Sharon—Columbia College of hysicians and Surgeons 1940.

Morris P. Pitock, Tufts Medical School 1930.

Arthur C. Unsworth, Hartford—University of ermont College of Medicine 1931.

John B. Wells, Hartford—Yale Medical School 937.

Executive secretary of the Society.

The organization meeting of the committee will e called by the President, Dr. Harvey, within a hort period.

Annual Meeting of the Council

The Annual Meeting of the Council was called to order at 3:30 P. M. on May 18, 1948 in the offices of the Society. There were present: Drs. Murdock, Howard, Gildersleeve, Gibson, Parmelee, Phillips, Sprague, Speight, Walker, Bishop, Barker, Miss Mooney. Absent: Drs. Harvey, Burlingame, La-Moure, Weld.

Dr. Murdock was unanimously elected Chairman of the Council for 1948-1949 and welcomed the new members of the Council, Dr. Charles H. Sprague, president-elect; Dr. Courtney C. Bishop, councilor for New Haven County and Dr. W. Bradford Walker, councilor for Litchfield County.

EMERGENCY MEDICAL SERVICE

The Council appointed Dr. William B. Smith, Hartford, chairman of a Committee on Emergency Medical Service and voted to transfer the budget alloted to the Committee on Military History to this new Committee.

"CALAMITOUS STATE AID PLAN"

The committee appointed by the Council to investigate the proposed Calamitous State Aid Plan reported that it was unable to recommend approval of the plan and it was voted to adopt this report.

STATE COMMITTEE ON FOOD, DRUGS, COSMETICS AND DEVICES

Dr. Gray Carter, Greenwich, was designated as the representative of the Society on this Committee.

RECOMMENDATIONS OF THE COMMITTEE TO STUDY ORGANIZATION AND OBJECTIVES OF THE SOCIETY

The Council considered at length the recommendations of the Committee to study the Organization and Objectives of the Society which were adopted by the House of Delegates at its Annual Meeting on April 27, 1948 and took the following action on the recommendations:

The executive secretary was authorized to proceed to obtain larger quarters for the offices of the Society when they are needed.

The executive secretary was authorized, whenever it appears necessary to him to obtain additional secretarial assistance.

The Council appointed Drs. Miller, Gibson and Burlingame as a committee to investigate the details of various retirement plans and report its findings to the Council.

The secretary reported that the fourth recommendation relating to compensation and public liability insurance had already been effected.

The secretary was instructed to employ legal counsel to obtain an opinion on the advisability of investigating the status of the Society in regard to exemption from unemployment Compensation Tax.

If counsel advises against requesting an official ruling from the Tax Commissioner, the secretary was instructed to inform the chairman of the Council.

The Council approved the purchase for ownership and maintenace by the Society and use by the executive officers in the conduct of official business an automobile at a cost not to exceed $2,000. Funds for this expenditure are to be drawn from the Annual Meeting surplus.

The secretary was instructed to prepare amendments to the By-laws to provide for succession of the elected officers of the Society in the event of death or incapacity.

The secretary was authorized to continue to make necessary changes and/or additions in equipment and procedure.

EXECUTIVE COMMITTEE

Dr. Harvey, president; Dr. Sprague, president-elect; Dr. Murdock, chairman of the Council; and Dr. Barker, secretary, were appointed by the Council to act as an executive committee during the summer months.

POSTGRADUATE EDUCATION

The Council voted to allot $4,200 from the general funds of the Society to the Yale School of Medicine as the Society's share in the financing of the programs of postgraduate education for the first year of operation.

SCHEDULE OF PROFESSIONAL FEES

At the request of the committee engaged in the study of the establishment of a uniform schedule of fees for professional services to state wards and agencies, the Chairman of the Council appointed a committee consisting of Drs. Gildersleeve, Walker, Bishop and Speight to confer with it and advise on the suitability of proposed fees for general and special services.

FIFTY YEAR MEMBERS

The Council requested Dr. Howard, Chairman of the Committee on Honorary Members and Degrees, to ask that committee to draw up a plan for recognizing and paying tribute to physicians who have been members of the Society for fifty years and submit that plan to the Council at a future date.

The Council appointed Dr. Francis A. Sutherland, Torrington, to the Committee on Tumor Study.

Twenty-four student members were elected and a list of them follows these minutes.

The meeting adjourned at 6:15 P. M.

Student Members

Merrill A. Baratz, New London
University of Rochester—Class of 1950
Pre-Med: Johns Hopkins University
Parent: John Baratz

Carl M. Bengs, Manchester
Georgetown Medical School—Class of 1951
Pre-Med: Trinity College
Parent: Maximilian A. Bengs

Helen M. Cappelli, Waterbury
Georgetown Medical School—Class of 1951
Pre-Med: Brown University
Parent: Daniele C. Cappelli

Roger G. Conant, West Hartford
Georgetown Medical School—Class of 1949
Pre-Med: Trinity College
Parent: W. Garrett Conant

Donald R. Cone, New Haven
Temple School of Medicine—Class of 1951
Pre-Med: University of Connecticut
Parent: Morris G. Cone

David K. Davis, Stamford
Georgetown Medical School—Class of 1948
Pre-Med: Fordham
Parent: David L. Davis

Wallace B. Dorain, East Haven
University of Chicago—Class of 1951
Pre-Med: Yale University
Parent: Hugh A. Dorain

Anne C. Dunbar, Danbury, Conn.
George Washington University Medical School—Class of 1949
Pre-Med: Colorado College
Parent: Robert C. Dunbar

Arnold Fieldman, Winsted
Tufts College Medical School—Class of 1951
Pre-Med: Yale University
Parent: Fred Fieldman

Kenneth F. Golden, Hartford
Syracuse University—Class of 1950
Pre-Med: Trinity College
Parent: Maurice H. Golden

Newell A. Johnson, Norfolk
University of Chicago—Class of 1950
Pre-Med: University of Conn.
Parent: Arnold Johnson

Harvey N. Mandell, Norwich
Dartmouth—Class of 1950
Pre-Med: Dartmouth
Parent: Simon Mandell

Henry S. Milone, New Haven
Georgetown Medical School—Class of 1950
Pre-Med: Yale
Parent: Peter Milone

Robert A. Nevins, Bridgeport
Georgetown Medical School—Class of 1951
Pre-Med: Mt. St. Mary's College
Parent: Edward A. Nevins

Myron K. Nobil, Meriden
Yale University
Intern—Meriden Hospital, Meriden
Parent: George B. Nobil

Francis M. Palmieri, New Haven
Georgetown Medical School—Class of 1950
Pre-Med: Providence College
Parent: Michele Palmieri

John A. Pierce, Hartford
Georgetown Medical School—Class of 1950
Pre-Med: Catholic University, Washington
Parent: Nathan C. Pierce

Joseph G. Rossi, Hartford
Georgetown Medical School—Class of 1950
Pre-Med: Trinity College
Parent: Joseph Rossi (deceased)

William L. Saunders, New Britain
University of Rochester—Class of 1949
Pre-Med: Princeton University
Parent: (father deceased) mother—Mrs. Catherine Saunders

Melchior F. R. Savarese, Jr., Orange
Georgetown Medical School—Class of 1949
Pre-Med: Yale University
Parent: Dr. Melchior F. R. Savarese

Eugene L. Serafin, New Haven
New York University Coll. of Medicine—Class of 1945
Intern at Kings County Hospital, Brooklyn, N. Y.
Parent: Dr. Peter J. Serafin

Sanford G. Weissman, New Haven
University of Chicago—Class of 1948
Pre-Med: University of Chicago
Parent: Abraham S. Weissman

Robert H. Wilkinson, West Hartford
Cornell University—Class of 1951
Pre-Med: Wesleyan University
Parent: Harold Wilkinson

Edmund F. Ziegler, New Britain
Georgetown Medical School—Class of 1950
Pre-Med: Holy Cross College
Parent: Henry J. Ziegler

Meetings Held During June

Tuesday, June 1, 4:30 P. M.
Board of Trustees of the Building Fund

Wednesday, June 2, 4:00 P. M.
Executive Committee, Committee on Tumor Study, Hunt Memorial, Hartford

Friday, June 4, 4:00 P. M.
Committee on Hospitals

Monday, June 7, 4:00 P. M.
Committee on State-wide Blood Bank

Wednesday, June 16, 4:00 P. M.
Committee on Tumor Study, Brady Memorial Laboratory, New Haven

Dr. Louis H. Bauer Secretary-General of World Health Organization

Dr. Louis H. Bauer has been selected as secretary-general of the World Health Organization with headquarters in New York City. Dr. Elmer L. Henderson, Louisville, Ky., chairman of the Board of Trustees of the American Medical Association, has been elected a member of the Council of the World Medical Association to fill the vacancy created by the appointment of Dr. Bauer.

The Council, consisting of 14 members representing 12 different countries, held a four-day meeting in New York, April 26-29. The Council is the governing body of the World Medical Association, which was organized in Paris on September 18, 1947 for the purpose of promoting closer ties among national medical organizations throughout the world. The Council's New York session was the first since the association's organization meeting in Paris.

Several AMA people were in attendance at the Council's sessions. Besides Drs. Bauer and Henderson, they were Dr. R. L. Sensenich, South Bend, president-elect; Dr. Ernest E. Irons, Chicago, secretary of the Board of Trustees; Dr. William Braasch, of the Mayo Clinic, Rochester, a member of the Board of Trustees; John L. Bach, Chicago, director of press relations, and Dr. Morris Fishbein, Chicago, editor of *The Journal*, who spoke on "World Medicine." Dr. Fishbein said that "if ever the traditions, the ethical principles and the high morale of the medical profession were needed by a distressed world, that time is now."

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND

Hartford County

Burdette J. Buck, Hartford
Andrew Taylor, Hartford

New Haven County

Harry A. Conte, New Haven



Elias Pratt

ELIAS PRATT 1859 - 1948

In 1939 when the Litchfield County Medical Association celebrated the 50th anniversary of Elias Pratt as a practitioner of medicine, the late Dr. Walter Steiner said of him:

"Long may he live to taste alike
Of age and youth the joys;
Old, yes, in years but in his heart
A boy among the boys!"

On May 28, 1948 this patriarch of Connecticut medicine and former president of the State Medical Society closed a long and distinguished career. The people of Torrington had a deep affection for Elias Pratt and with regret bade him farewell two years ago when he retired, after 56 years of practice, to make his home with his son in Essex, his birthplace. Dr. Pratt traced his ancestry through both his father and mother to sturdy pioneers who came to the United States aboard the Mayflower. One of these, Lieutenant William Pratt, a settler of the Hartford Colony, in 1678 established a blacksmith shop in Essex and this shop continued in direct succession from father to son for eight generations.

Educated in the schools of Middletown and Hartford, Elias Pratt continued his preparation at the College of Physicians and Surgeons, Columbia University, from which he received his M.D. degree in 1887. An internship at the Charity Hospital on Blackwell's Island followed. Then after a short period of practice in New York City he went as a ship's surgeon to Denmark, and finally settled down to practice on January 19, 1889 in the Smith House on Main Street in Torrington. His village paper, the *Deep River New Era*, predicted "as an earnest Christian gentleman he would win the respect, confidence and love of the people with whom he had chosen to make his home."

Twice president of the Litchfield County Medical Association, and its councilor to the State Society from 1910 to 1922, Elias Pratt was active in the interests of his fellow practitioners. For two periods of seven and four years each he served on the State Society's Committee on Public Policy and Legislation, as vice-chairman from 1930 to 1931 and as chairman from 1931 to 1932.

His accomplishments in the cause of public health will long remain a tribute to his leadership. When Dr. Pratt was a member of the General Assembly during 1899 and 1901 many laws safeguarding the public health were passed through his influence. These laws concerned the protection of the milk supply, clean dairies, the elimination of diseased cattle, the abolition of the dipper can, the dead fly system of dishing out milk in public eating places, and a number of other measures.

Another example of Dr. Pratt's interest in protecting the health of Torrington's citizens occurred in 1918 during the influenza epidemic when he secured from the School Board the use of the high school building for an emergency hospital. So forehanded was he that, on the evening of the day he received authority for this emergency hospital, 35 patients were admitted. The resulting death rate in Torrington during the epidemic was so low that it drew an inquiry from the Department of Public Health at Yale as to the cause.

Elias Pratt served as health officer of Torrington for nearly half a century. His period of service as school physician and city physician also covered several decades. He was a president of the Connecticut Public Health Association, a trustee of the Institute of Living, the first chief of the medical staff of the Charlotte Hungerford Hospital, and a charter member of the Torrington Rotary Club, the Torrington Historical Society, and the Litchfield County Automobile Club.

"Master, I've done Thy bidding, and
the light is low in the west,
And the long long shift is over . . .
Master, I've earned it—Rest."

NEW ENGLAND CONFERENCE OF INDUSTRIAL PHYSICIANS

Modern management considers the industrial physician "a most important personnel ambassador" and a valuable contributor to production through maintaining the health of the working force, according to Allen W. Rockwell, works manager of the American Brass Company, Waterbury.

Addressing more than 200 industrial physicians, nurses, and safety engineers at the annual dinner of the New England Conference of Industrial Physicians and Surgeons at the Hotel Bond, Hartford, on May 27, Mr. Rockwell emphasized that the principles of occupational medicine contain powerful factors for industrial progress.

However, it is often found that these principles must be "sold" to management. "It's a selling job, not merely requests for authority, that is needed," he declared.

Industry can prosper only so long as it maintains and advances production, the speaker emphasized, and stated that its medical departments must be considered as part of the production team.

The address by Mr. Rockwell concluded the all-day conference, during which the principal phases of occupational medicine and safety engineering were discussed by speakers from Connecticut, New York, Massachusetts, Rhode Island, and Illinois.

Asserting that "it is the duty of Connecticut industry to provide for advanced research in industrial medicine," Dr. Thomas P. Murdock, Meriden, chairman of the State Medical Society's governing Council, declared at the morning session that medical departments in modern industrial plants are cutting down absenteeism, saving lives, and contributing to the health of workers. He condemned proposals for socialized medicine as foolish beliefs that mere changes in administrative techniques can provide better health services.

Presenting a viewpoint of industrial management, H. W. Schwartz, vice-president of the Robertson Paper Box Company, Montville, stated that within the past few years management has come to full realization that almost any expenditure for the improved health of employees is a good investment.

"In order to get high standards of efficiency we cannot employ workers inferior physically or mentally to their jobs," he declared. Outlining the problem in terms of profit and loss, Mr. Schwartz stressed the fact that the average American worke loses 9 days of production time per year becaus of illness and accidents. Added to this cost must b production losses incurred by unfit workers oper ating expensive, high-speed machinery, and the fa greater cost of damaged morale and goodwill, h concluded.

Growing pressure from labor organizations for full-scale medical-care plan in industry may exac some programs in this direction within the next few years. This opinion was expressed by Dr. Daniel L Lynch, medical director of the New England Tele phone and Telegraph Company, Boston, and pas president of the American Association of Industria Physicians and Surgeons. He told the group that it is becoming increasingly difficult for industria physicians to convince workers that only work-incurred disabilities can be treated within the plant. Labelling the health fund of the United Mine Workers as one of the main opening wedges in labor's program for complete medical services on the occupational level, the pioneer industrial physician declared that employee benefit plans and unemployment insurance have raised serious problems of absenteeism.

In introducing members of an afternoon panel discussion on cooperative relationships in occupational medicine, G. R. Fugal, personnel manager of the General Electric Company, Bridgeport, laid responsibility for the attitudes of employees at the door of management.

"Employee attitudes are conditioned by management," he asserted, and added that "We ought to realize that we're in business to do some good for somebody—not just ourselves."

Sound principles of human engineering must be relied upon by management today to develop the latest possibilities of its production force, and this cannot be done merely by initiating higher pay scales, the personnel manager told his audience.

"You cannot buy enthusiasm, loyalty, devotion—you cannot buy hearts, and minds, and souls," he declared.

As discussant for the panel, Dr. Carl Peterson, secretary of the Council on Industrial Health of the American Medical Association, accented the importance of human relations and its direct connection

ith industrial medicine. "I firmly believe," he said, hat the job of human relations is so comprehen-ve, so vast, that it is today's greatest challenge to dustrial medicine." He expressed confidence that e principles of sound relationships will in the next w years progress beyond all expectations, and that is period will bring management closer than ever fore to industrial medicine.

The last speaker on the panel, Dr. Charles W. off, Hartford orthopedic surgeon, raised a provoc-ive discussion when he declared that industrial urses should "be seen but not heard." He stated at, while industrial physicians place high value on the services of their nurses, sometimes a com-ent by a nurse is taken too literally by an nployee-patient, and this creates difficulty in bsequent treatment by the physician. Dr. Goff so declared that "the weakest link" in the indus-ial production chain is the foreman trained only r production and not for the adjustment of em-loyees to their work.

Strenuous exceptions to both statements were oiced by Robert T. Collins, personnel director of e New Departure Division of General Motors orporation, Bristol. He stated that in his plant mployees are assigned to their jobs directly from e personnel department, and that foremen are rained in this procedure, and also declared that ndustrial nurses, in his opinion, should be per-itted to speak as freely as the situation demands in rder to give proper patient care.

In his rebuttal, Dr. Goff said that the problems as e had stated them were largely applicable to small-r industries, that he could see how they might not pply to a large, more developed industry, but that his did not obviate the principles involved.

Other participants in the discussion were Dr. Donald V. Baker, medical director of Lever Brothers Company, and Conference vice-president; Mrs. Mary Delehanty, president of the American Association of Industrial Nurses; and Everett W. Martin, Liberty Mutual Insurance Company, and past president of the Connecticut Safety Society.

Speaking at the afternoon session on "The Train-ng of Industrial Physicians and Nurses," Dr. Ronald F. Buchan, clinical director of Yale's Insti-ute of Occupational Medicine and Hygiene, stressed the importance of "reasonable agreement" among industrial physicians concerning the scope of educational programs in this specialty.

Until such agreement exists, "educational centers will not hasten to institute these programs," he declared. Not only must accord be reached in developing postgraduate courses, but adequate steps must be taken in undergraduate education, Dr. Buchan pointed out.

He characterized the situation as one requiring more discipline and organization, and stated that the efforts of a few medical schools to establish departments of occupational medicine will prove of little worth unless other institutions follow suit.

Operating features of the Hartford Small Plant Medical Service were described by Dr. Robert L. Quimby, its director, and the afternoon session concluded with a discussion led by Dr. Stanley Sprague, medical director of the J. and L. Coats Company, Providence, R. I., and past president of the New England Conference.

The meeting was sponsored by the Industrial Health Committee of the State Medical Society. Dr. C. Frederick Yeager, committee chairman, presided at the morning and evening sessions with Dr. J. Robertson Knowles, of Boston, Conference president.

Guest sponsors included the Occupational Health Council of the Manufacturers Association of Connecticut, the Industrial Nursing Section of the Connecticut States Nurses' Association, and the Connecticut Safety Society. Dr. Crit Pharris, assistant medical director of the United Aircraft Corporation, East Hartford, was chairman of the committee which planned the conference. Committee members were Dr. Albert S. Gray, director of the Bureau of Industrial Hygiene, Connecticut State Department of Health; Dr. John N. Gallivan, medical director, United Aircraft Corporation; Dr. Ronald F. Buchan, Yale University School of Medicine; and Dr. Ellwood C. Weise, Bridgeport.

Wisconsin Purchases New Home

The State Medical Society of Wisconsin has recently purchased a two and one half story brick building to house the headquarters staff.

The new quarters are large enough not only to house the Medical Society staff but also the offices of the Wisconsin Veterans Medical Service agency and the Wisconsin Physicians Service. Space will also be available for Council and Society meetings.

NUTRITION COUNCIL ANNUAL MEETING

The enrichment of foods with synthetic vitamins is a practical approach to the nation's dietary deficiencies.

But it cannot be considered a permanent solution, and should be supplemented by improved agricultural practices and the increased production and use of milk.

These views were expressed by Dr. Robert R. Williams, member of the Food and Nutrition Board of the National Research Council, during an address before one hundred members of the Connecticut Nutrition Council at their annual dinner May 26 in the Hotel Taft, New Haven.

A pioneer in synthesizing Vitamin B1, Dr. Williams stressed the importance of the world's grain crops as the most useful human food. In the Orient, where for several years he conducted experiments on the vitamin content of rice, Dr. Williams said that the term "agriculture" can be thought of simply as "rice-culture," so important is this crop to the nutrition of the people. Rice, wheat, and corn still remain the staple foods for millions of people, he pointed out, and cited as proof the fact that while a total of 35 millions of tons of foodstuffs were shipped in international commerce in 1947, 30 million tons constituted these three leading cereal grains.

But all of these grains have shortcomings—they are deficient in some of the essential amino acids, and are low in calcium and phosphorous content. Refined milling, instituted as a safeguard against destruction by insect pests and rodents, has seriously reduced the nutritional values of both wheat and rice, he declared.

Aiming toward the correction of these deficiencies in wheat, the Food and Nutrition Board of the National Research Council has developed the present flour-enrichment program in this country, he explained. The program is not "a nutritional panacea," and it is felt that its current widespread use is materially protecting the population from the ravages of many deficiency ailments.

Twenty-one states have now passed legislation requiring flour enrichment, Dr. Williams pointed out, and added there are good prospects Massachusetts and Rhode Island will be added to the l this year.

In addition to the enrichment of wheat flou programs have been launched recently for the add tion of synthetic vitamins to milled rice and cor At Clemson College, South Carolina, an attachme for corn-milling machines has been perfected and being offered to hundreds of small millers in th state for $25. The attachment utilizes a "vitamin mix," also supplied to millers by the college, and i use is being promoted through a widespread educa tional campaign. Expansion of this program, D Williams said, is expected to eventually wipe ou pellagra in the Southern States.

Although rice is not an important item in th American diet, the Research Council has deemed of sufficient value to launch an experimental pro gram in rice milling in Texas. First experiment centered about the parboiling of the grain, but thi process was found to be too expensive for com mercial use, Dr. Williams explained. In its stead machinery has been developed to fortify rice kernel with synthetic vitamins through steam pressure and the cost of this process has proved commer cially feasible.

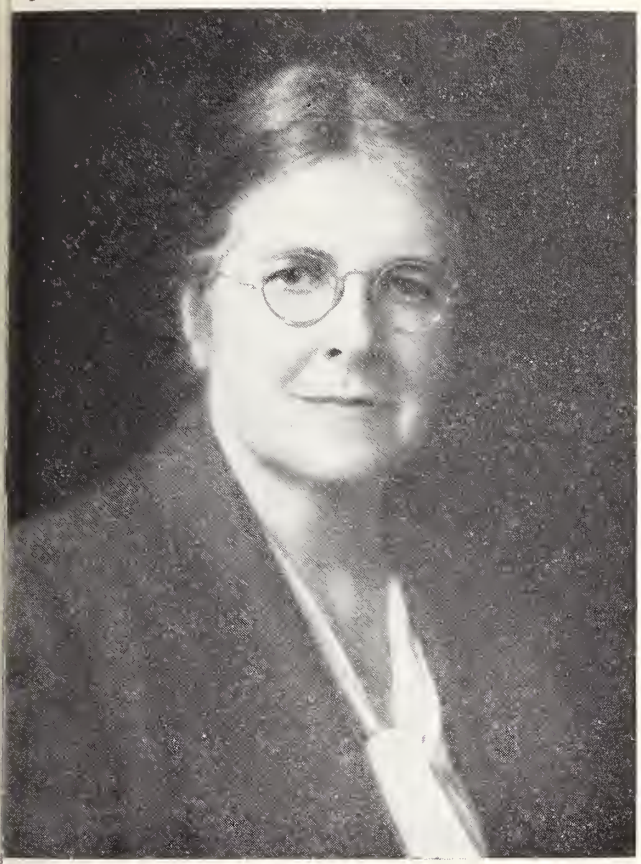
On the Philippine island of Bataan a program o rice enrichment and rigid dietary control now being conducted by the Philippine government with the aid of the United States Department of Health will show a dramatic decrease in the incidence of beriberi, Dr. Williams predicted.

At a business meeting preceding the dinner Mrs. Martha Smith Fry, Wallingford, was elected chairman of the Council; Ross A. Gortner ,Jr., Wesleyan University, vice-chairman; Miss Nellie S. Buckey, supervisor of Home Economics Education, State Department of Education, secretary; Miss Cora E. Webb, University of Connecticut, assistant secretary; and Miss Erna Fisher, Hartford Electric Light Company home economist, treasurer.

Earlier in the day members of the Council toured the Yale University Nutrition Laboratory as guests of Professor George R. Cowgill.

CONNECTICUT PHYSICIANS RECEIVE HIGH HONOR

Two members of Society Represent United States at World Health Assembly



MARTHA M. ELIOT, M.D.



JAMES R. MILLER, M.D.

Two prominent members of the Connecticut tate Medical Society, Dr. James R. Miller, Hartord, and Dr. Martha M. Eliot, Washington, D. C., e representing the United States at the first World Iealth Assembly now in session at Geneva, Switzerand.

Also a member of the delegation is Dr. Thomas . Parran, formerly surgeon general of the United tates Public Health Service. The delegates were ppointed by President Truman following passage f enabling legislation by Congress.

The Assembly convened in Geneva on June 24, nd marks the beginning of full scale activity of the Vorld Health Organization, a specialized agency f the United Nations. Delegates are in attendance rom 34 member nations, and it is anticipated that a engthy agenda will require the Assembly to remain n session for at least thirty days.

In representing the United States, both Dr. Miller nd Dr. Eliot are prepared with wide knowledge of ealth conditions gained through years of expeience in organized medicine and related fields.

Dr. Eliot is associate chief of the Children's Bureau, U. S. Department of Labor, a member of the National Research Council, the Commission on Child Development, and the Commission on Food and Nutrition. Formerly a resident pediatrician at the New Haven Hospital, she has retained membership in the New Haven County Medical Association and the State Medical Society since 1937.

President of the State Medical Society in 1947-1948, Dr. Miller is a trustee of the American Medical Association and a member of the Board of Governors of the American College of Surgeons. He is also chairman of two committees of the American Cancer Society, the National Service Committee and the Medical and Scientific Committee.

Dr. Woodward President E. E. N. T. Society

Harold B. Woodward of Bristol has been elected president and Louis D. Harris of Hartford, secretary of the Hartford Eye, Ear, Nose and Throat Society. At the annual meeting of the Society Sylvan Moulton, pathologist at St. Peters Hospital, New Brunswick, N. J., spoke on "Diagnosis of Pituitary Tumors." Gilbert W. Heublein of Hartford discussed the treatment of this group of tumors.

Diabetic Association Planning State-Wide Operation

The Connecticut Diabetes Association, organized in Fairfield last April during the 156th annual meeting of the State Medical Society, is now perfecting its plans for state-wide operation next fall.

At a recent meeting of the association's council it was voted to establish professional and associate classes of membership. Professional memberships will be open to all physicians, and policy control will be vested in this group. Associate members will include diabetics, their relatives and friends, nurses, pharmacists, public health officials, laboratory technicians, social workers, nutritionists, and other allied groups.

Dr. Barnett Greenhouse, New Haven, president of the new association, announced recently that the council has set annual dues at one dollar per member. Plans of the association do not call for fund-raising campaigns, it being felt that its activities as now envisaged can be adequately supported by membership dues.

The broad program of the association is to be developed in three general directions: education of relatives and friends in the proper care of diabetics; standardization of treatment for the disease; and promotion of the principle of early diagnosis.

Steps are now being taken to affiliate with the American Diabetes Association and the New England Diabetic Association. When this is completed, Connecticut will become the ninth state to establish a program affiliated with the American Diabetic Association. The organization plans to form local chapters, first on a county basis, then by key communities at a later date.

Other officers of the association are Dr. Burdette J. Buck, Hartford, first vice-president; Dr. Anthony Cipriano, New Haven, second vice-president; and Dr. John Dobkins, Stamford, secretary.

Members of the association's council are Dr. C. N. Hugh Long, dean of the Yale University School of Medicine; Dr. Eugene E. Lamoureux, director of the Bureau of Preventable Diseases, Connecticut State Department of Health; Dr. Samuel J. Goldberg, Dr. Herbert Levine, and Dr. Bernard L. Kartin, New Haven; Dr. Michael Brodsky, Bridgeport; and Dr. Max Ruby, Waterbury.

Governor Appoints Dr. Marshall

Carter L. Marshall, M.D., of New Haven wa recently reappointed to membership on the Con necticut Inter-Racial Commission by Governo James C. Shannon. A member of the Connecticu State Medical Society, the New Haven Count Medical Association, and the American Medica Association, Dr. Marshall has practiced medicine i Connecticut since 1926. He received his medica degree at Howard University in 1924, and hi academic degree at Williams College in 1920.

General Practitioners Hold Election in September

Permanent officers of the Connecticut Chapter American Academy of General Practice, will b elected at an annual meeting to be held in Septembe during the Clinical Congress.

The announcement was made recently by Dr Michael W. Palmieri, New Haven, acting secretary of the group. Other temporary officers are Dr. Julius H. Grower, Middletown, chairman; and Dr. Walter V. Corey, Hamden, treasurer.

The first meeting of general practitioners interested in forming the Connecticut Chapter was held in Middletown last November. This was followed in January by a meeting in New Haven, and further plans for organization were formulated when charter members met in Fairfield during the 156th annual meeting of the State Medical Society.

To be eligible for membership, physicians must be engaged in general medical practice, and must have completed at least three years of such practice. Special consideration is given in cases of military service. Also, applicants must have had at least one year of rotating internship at an approved hospital, or the equivalent in postgraduate training. Though the Academy has no direct connection with the American Medical Association, membership in the AMA is required of all applicants for acceptance.

Connecticut Public Health Association Elects

George B. Davis of Norwalk has been elected president of the Connecticut Public Health Association and Benjamin L. Pennell of New London, vice-president.

Appointed Member of Connecticut Medical Examining Board



Carl E. Johnson, M.D.

The appointment of Dr. Carl E. Johnson, New Haven, as a member of the Connecticut Medical Examining Board was recently announced by Governor James C. Shannon.

The appointment was made upon the recommendation of the president of the State Medical Society, and fills a vacancy created last month when Dr. George M. Smith, Pine Orchard, resigned for reasons of health after more than twenty-two years of service on the Board. The term of the appointment expires December 31, 1950.

Dr. Johnson is chief of obstetrics and gynecology at the Hospital of St. Raphael, New Haven, and has practiced medicine in Connecticut since 1932. He is a diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Surgeons, and a member of the New England Obstetrical and Gynecological Society. Following graduation from Leland Stanford University in 1922, Dr. Johnson attended Harvard Medical School and received his degree in medicine there in 1926. He is chairman of the Program Committee of the State Medical Society.

Connecticut Medical Veterans Elect

The annual business and election meeting of the Connecticut Veterans Administration Medical Society was held on June 3.

The new officers and standing committees are: President, Morris Dressler; Vice-President, George Bassow; Secretary, John Trapuzzano; Assistant Secretary, Joseph Brandriss; Program Committee: Chairman, Isadore Schnap, Edgar Prout, Stewart Siegle. Publicity Committee: Chairman, Emanuel Marcus; Elmer E. Thomas, Robert Levin. Library Committee: Chairman, Agha Musa; Joseph Brandriss, John Trapuzzano. Welfare Committee: Chairman, George Roch; Francis Harrington, Arthur Griswold.

During the summer months meetings will be held every Thursday from 8:30 to 9:30 A. M. at 95 Pearl Street, and the following two courses will be given:

1. X-ray Diagnosis by Morris Levine, chief roentgenologist, Hartford Regional Office.

2. Electrocardiography by Morris Dressler, chief of medicine and chief cardiologist, Hartford Regional Office.

Dr. C. L. Deming Heads G. U. Surgeons

Clyde L. Deming of New Haven was elected president of the American Association of Genito-Urinary Surgeons at the 59th annual meeting of the Association held at Skytop, Pennsylvania, recently.

Dr. W. J. Reilly of Naugatuck Honored

Walter J. Reilly, Lieutenant Commander, MC—USN, in World War II was given a testimonial dinner on May 8 by the Naugatuck Valley Detachment, Marine Corps League. While in the Navy Lieutenant Commander Reilly was the medical officer on the KA-14 which carried Marine troops to combat. On this assignment he treated hundreds of seriously wounded marines. The Naugatuck Valley Detachment, to show their appreciation of Dr. Reilly's service, have made him an honorary member. This election will automatically make him the detachment physician.

The dinner was held in Odd Fellows Hall, Naugatuck, and was attended by several past state commandants.

Public Health Association Meets in New Haven

Connecticut has ten thousand children with defective hearing, and in at least half of this group the defects are so severe that they interfere with educational progress.

Speaking at the annual meeting of the Connecticut Public Health Association, held May 12 at the Yale University School of Medicine, Norton Canfield, associate professor of otolaryngology, outlined the problem of defective hearing among the state's school children as one which requires the remedial efforts of all agencies and interested individuals.

The means are now at hand for rapid and effective action in this situation, he emphasized, explaining that war-time developments in electronics have produced instruments that control sound so precisely that former types of hearing tests are outmoded. Such instruments are now available in mobile, sound-proofed trailer units, he said, and recommended that the possibility of utilizing this type of equipment for auditory testing of school children be investigated by responsible agencies.

Speaking on "Vision Testing," Eugene M. Blake, clinical professor of ophthalmology, told of a survey now being conducted by the United States Children's Bureau in the schools of St. Louis to discover the incidence of vision ailments and their effect upon scholastic abilities. He stated the survey is the most complete to be conducted in this country, and its results should prove of special value to educators and physicians.

The approximately 200 physicians, nurses, public health officials, educators, and health workers who came from all sections of the state to attend the conference were greeted at the first morning session by Professor Ira V. Hiscock, chairman of Yale's Department of Public Health. The afternoon session was devoted to panel discussions on public health practices and the role of the general hospital as a community health agency.

The annual banquet, held at the New Haven Lawn Club following the all-day conference, was the scene of special tributes paid to Dr. Stanley H. Osborn, State Health Commissioner, in observance of his completion of 25 years in public service. Greetings were extended by Governor James C. Shannon and New Haven's Mayor William C. Celentano. Dr. Alfred Burgdorf, health officer of Hartford, was toastmaster and presiding officer was Dr. Thomas J. Bergin, president of the Association.

Easy Acres Has New Head

Easy Acres Foundation, a non profit hospital for treatment of the problem of the alcoholic, will continue under the direction of its medical staff George Leary of Wilton and New York, president of the Foundation, announced recently.

Edward J. McDermott, a graduate of the Yale Institute of Alcohol Studies, who founded Easy Acres three years ago, died on May 10, and funeral services were held on May 13 at St. Mary's Church Derby.

Under the direction of Dr. Francis Paul of Norwalk, member of the American Board of Psychiatry as medical director, and Dr. Francis B. A. William of Monroe as assistant medical director, the Easy Acres Foundation will continue here the care and treatment of alcoholic patients of whom more than 300 have been provided for during the past year Mr. Leary said.

"The death of our managing director, Mr. McDermott, was a serious loss," Mr. Leary said, "but we are going forward with our plans for expansion of the facilities of Easy Acres that had been worked out before his sudden and untimely death. The need for the service which the Foundation is providing is more urgent than ever before and we are doing our best to meet it."

The Easy Acres Foundation was incorporated early this year as a non profit institution, the other officers being Joseph Foster of Greenwich, Everett A. Gilcreast of New Haven, secretary, and Austin Mather of Norwalk and Bridgeport, treasurer.

Dr. Girouard Knighted by Bishop O'Brien

Joseph Arthur Girouard, a practicing physician in Willimantic for nearly half a century, was appointed Knight of St. Gregory the Great by Most Rev. Henry J. O'Brien on February 5. On June 27 a testimonial dinner was tendered Dr. Girouard by St. Mary's parish.

Dr. Girouard is a member of the staff of the Windham Community Hospital. In 1939 he was honored by the minister of national education of the French Republic with the title of Officier d'Academie for services rendered in the interest of French culture.

New Britain Memorial Hospital Center for Care of Aged and Sick Women

The Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm has selected the New Britain Memorial Hospital for the State program for the treatment of women coming within this category. A similar program has been inaugurated for men at the Veterans Home in Rocky Hill.

It was reported the Commission intends to put the program into operation soon after completion of the changes now being made at the Memorial Hospital that will make possible the addition of 25 more beds. According to present plans the Commission expects to request the use of about 40 beds for cases under its care, the number being increased with the future expansion of the hospital.

The state program for the care and treatment of ill women offers the New Britain area a great opportunity to create a model hospital, the Commission indicated. It reported the state will contribute towards the expansion of the institution if people in the New Britain area also contribute. For years the state has been paying for the care of aged and chronically ill persons unable to support themselves by placing them in convalescent homes or in private hospitals. The Commission says that the treatment in these places has not been below standard, but pointed out their charges should receive physical and occupational therapy under a rehabilitation program. Institutions such as the New Britain Memorial Hospital will provide these services, the Commission reported.

The new program was authorized by the 1947 State Legislature and is jointly administered by the State Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm and the Veterans Home Commission. Col. Raymond F. Gates, commander of the Veterans Home and Hospital, is chairman of the joint action. Dr. Joseph N. Howard of Bridgeport is chairman of the Commission on the care of the chronically ill and Dr. A. N. Creadick of New Haven is the medical director.

The purpose of the program, Dr. Creadick said, is to rehabilitate patients to a degree that will permit them to return to their families or foster homes, thereby not requiring complete supervision. In the not too distant future, Dr. Creadick predicted, the Town Home will vanish and will be supplanted by dormitories which will permit a husband and wife to live together in their old age.

The Board of Directors of the New Britain Memorial Hospital has applied for Federal and State grants to aid in its expansion program.

Blue Cross Announces Bonus on Maternity Cases

Connecticut Blue Cross members applying for maternity benefits during the next few months are in for a pleasant surprise. Robert Parnall, general manager of the hospital plan, announced recently that all eligible maternity cases admitted to hospitals from May 17 through August 1948, will receive a bonus benefit of $15 per case in addition to the regular $65 credit provided in the Blue Cross rules and regulations.

"This action fulfills a long standing desire on the part of Blue Cross directors," Parnall said, "and has been fully approved by the Insurance Commissioner." The bonus was made possible, he stated, by the absence of abuse of privileges by members and strict adherence to low cost, non profit operation. He expressed hope that the bonus could later be extended beyond the three-month period and that a policy of bonuses for other types of hospital care would be possible in the future.

National T.B. Association Poll in Hartford

As part of the five-year survey being made by the National Tuberculosis Association on its educational materials, methods and results, two pilot centers were chosen, Denver and Hartford. In the latter poll 548 persons were interviewed and a series of 12 questions were drawn up by Hartford authorities. A 13th question was added by the investigators, Benson and Benson, Inc., of Princeton, N. J.

About 8 out of 10 said tuberculosis can be transmitted from person to person, only two-thirds stating that it is caused by a germ. Only 30 per cent realized that tuberculosis is not an hereditary disease. X-ray was named by 54 per cent as the physician's best means of finding the disease early, but only 47 per cent had ever had a chest x-ray.

It was very significant that the younger the person interviewed, the better his level of education; the higher his income bracket, the more he knew about tuberculosis. This indicates that among population groups that have been found to have the greatest tuberculosis mortality and the highest death rate due to the disease, is also found the major need for sound health education.

CONNECTICUT CANCER SOCIETY

New Project of State Cancer Society

An undertaking that will enable tumor clinics throughout the state to benefit from the counsel and services of skilled cancer specialists has been launched by the Association of Tumor Clinics, following discussions on the plan between the Association and the Medical Advisory Committee of the Connecticut Cancer Society.

The project, considered unique as a statewide service, will bring medical leaders, selected from a panel of consultants, to regular conferences of individual clinics. It is being financed by funds from the Cancer Society.

The activity is considered by officials of the Association and the state cancer group as an outstanding forward step in the services extended to tumor clinic patients, and as a development that will strengthen the entire state cancer program.

Under the project the services of the consultant requested will be at the disposal of the clinic for help with particular diagnosis and treatment problems, or for discussion on general principles in the consultant's field. The clinic specifies the specialist it wishes to have, and he may be invited for single visits or for a series of visits.

"The service will be of special benefit to the smaller clinics, and to those which are more distant from metropolitan centers," a statement from Dr. Creighton Barker, president of the Connecticut Cancer Society, pointed out.

Visits from panel representatives have already been requested by several clinics, and it is expected that the project will be established as a permanent phase of the Association's work. Engagements are being scheduled through Dr. Robert Tennant of Hartford, secretary of the tumor group.

Panel constituents, approved by the Association's executive committee, are: Surgeons: Samuel C. Harvey, Edward J. Ottenheimer, Ashley W. Oughterson, Max Taffel, John O. Vieta and N. William Wawro. Gynecologists: Carl Johnson, Louis F. Middlebrook and Arthur Morse. Urologists: Phillip Cornwall and Chris Neuswanger. Radiologists: Gilbert Heublein, Arnold H. Janzen, Ralph Ogden, Berkley Parmelee and Hugh Wilson.

Francis Sutherland of Torrington is chairman of the Association of Tumor Clinics. Other members of the executive committee are: Drs. Tennant Averill Liebow of New Haven, Edward J. Ottenheimer of Willimantic, and Louis G. Simon of Norwalk.

Only AMA Emblems Are Official for Use by Doctors

In recent months various commercial sources have been offering for sale to physicians automobile emblems resembling the official emblem issued by the American Medical Association through its component state medical societies.

The emblem issued by the AMA is the only official emblem for use on the automobiles of physicians. These are stamped with individual registration numbers so that the names of physician owners may be filed in each state medical society office. Connecticut physicians may secure these official emblems at the State Medical Society office in New Haven.

New Medical Library at Middlesex Hospital

Middlesex Hospital, Middletown, is to have a new medical library in memory of the late Dr. John E. Loveland. This has been made possible by a subscription of $12,000 by Mrs. Loveland to the $500,000 fund being assembled for the enlargement and modernization of that hospital. The new library will be an important and integral part of the projected medical board room for the attending staff.

Dr. Loveland was the moving spirit in founding the present library at Middlesex Hospital in 1924, one of the best in the country among hospitals of comparable size. Before her marriage in 1907 Mrs. Loveland was superintendent of Middlesex Hospital.

Dr. C. E. Stephenson Honored

Charles E. Stephenson, associate neurologist at Hartford Hospital, was elected chairman of the Eastern Association of Electroencephalographers at the recent annual meeting held in Bethesda, Maryland.

Dr. Stephenson has accepted an appointment as assistant professor of psychiatry in the University of Vermont Medical School. He will assume his new post on July 1.

PUBLIC RELATIONS ARE RELATIONS WITH PEOPLE

Doctors meet all kinds of people every day

What these people think is public opinion

Help your people to think well of medicine

Every Doctor
Creates Public Opinion

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, John G. Frothingham, New Canaan
Hartford County, James R. Cullen, Hartford
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Richard F. Grant, Cromwell
New London County, Edmund L. Douglass, *Chairman* Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, William Schneider, Rockville
Windham County, William S. Maurer, Willimantic



PUBLIC AFFAIRS

LOOPHOLES IN DISABILITY INSURANCE

ALBERT STUMP, *Indianapolis*

The Author. *Counsel for the Indiana State Medical Association*

INSURANCE is a highly technical business. The experienced and capable insurance man may be regarded as a professional man. One of the characteristics of a profession is that there develops within it a vocabulary with which the members of the profession become familiar, but with which the layman, with respect to that profession, is not familiar. For that reason the most important guard against undesirable and inadequate insurance protection lies in the selection of an honest and intelligent insurance agent, personally known to you, who is seriously and studiously making insurance his profession. Such a man, knowing that he is likely to have to face you and your friends when the situation arises where you expect the insurance as you understood it to come to your aid, is not likely to overstate the protection afforded in the policy he sells you. He does not want to face the tragic result if you find yourself without the protection for which you thought you had paid. Life insurance agents making that calling a profession do not depend to any great extent on disability insurance. Many life insurance companies do not write it. Therefore, the professionally-minded life insurance agents may be more likely to approach your disability problems without bias or prejudice, but with considerable knowledge regarding the whole subject of insurance protection and with your interests paramount.

TYPES OF POLICIES

To illustrate the difficulties the "insurance layman" may have with the insurance man's professional vocabulary your attention is invited to five types of disability income policies being sold. They are:

1. Cancellable policies in general—which may be cancelled at any time before a claim arises or after a claim has been paid.

2. Non cancellable term policies—which generally cannot be cancelled for the year for which the premium was paid and accepted by the company, but which can be renewed after the period covered by that premium only with the consent of the company. These policies are likely to be particularly misleading. The company ends its responsibility and terminates the insurance simply by refusing to accept the premium and renew the policy at the end of the year covered by the last premium paid. The reason for calling them non cancellable is that they cannot be cancelled during the year for which the premium was paid, as may be done with cancellable policies.

3. Non cancellable renewable policies—on which renewal premiums may be increased above the premiums formerly paid.

4. Non cancellable renewable fixed-premium policies—which carry definite provisions for increasing the premium in accordance with the increase of the age of the insured and which give the insured the absolute right to renew.

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5. Non cancellable renewable level-premium policies—on which the premium remains unchanged and which the insured has the absolute right to renew.

Because of the possibility of confusion and deception in connection with the sale of non cancellable policies where right of renewal depends on the consent of the company, some states have prohibited by law the sale of such policies as non cancellable policies. Too many will not realize that the policy may be ended by the refusal of the company to renew it. The result is the same as if the policy could be and was cancelled.

INSURED AGAINST WHAT?

A technical feature that is almost certain to escape consideration by the layman buying accident insurance is to be found in the insuring clause. That is the part of the policy that states the conditions under which the benefits of the policy are to be paid. These clauses vary in different policies. One of the important questions regarding that clause is whether the company pays because of bodily injury "received through accidental means," or because of "accidental bodily injury." The first clause covers unintended means—that is, the means bringing about the injuries must be unintended. For instance, in Kendall v. Travelers Insurance Company, 87 Oregon 179, the court held that an abrasion by a barber as a result of his attempting to remove ingrowing hair at the request of the insured was not an accidental but was an intended means, and therefore the results of removing the ingrowing hair did not come within the insuring clause.

Another court held that shaking down ashes in a furnace from which the insured was injured was not covered because the means was intentional. In another case it was held that infection arising from rubbing a toe with a towel, which resulted in a bodily injury, did not involve an accidental means.

On the other hand, if the insuring clauses in these disability policies covered "accidental bodily injury" the policies would have covered the injuries sustained.

Another highly technical and often controversial question is, when is a person disabled? Is it only when he is unable to do anything at all, or only when he is confined to his house, or only when he is confined to a bed? If it requires that he be confined continuously within doors, then if he sits in the yard or on his porch or makes an automobile trip his disability benefits are terminated. Suppose a person suffers a stroke of paralysis, as a result of which he is impaired to the extent that he cannot carry on his business. If his disability policy contains a house confinement clause he would be compelled to stay in his house for the rest of his life if his financial condition required him to depend on his disability benefits. If disability means inability to perform all the usual tasks connected with his regular profession or employment, one situation exists; but if it means only some one or more essential duty in order to carry on his profession, another situation exists.

THE POLICY, NOT THE ADVERTISING, CONTROLS

This should be sufficient to indicate the highly technical elements in insurance. But insurance is often sold by the advertising, by the oral persuasion of the agent, or by the recommendation of some other person who himself may not have taken the time to check the policy against a definite outline for analysis which would disclose its actual merits and demerits. It should be remembered that the insurance company is not bound by the statements of its agents. The policy itself is the contract which establishes the obligation of the company. An analysis of the policy sometimes discloses that the policy falls far short of what the physician or other buyer of insurance thought it was. He listened too intently to the statement of agents or the recommendation of friends, or read the advertising with too much credulity. There is but one means of determining what the company's obligations are, and that is an accurate analysis of the policy itself. If any agent refuses to give you a specimen copy of a policy for study and analysis by one who is competent in that work, you can be sure that there is some reason for withholding the sample policy other than the best interest of the person being solicited.

The physician or other person buying disability insurance should not expect any financial miracles from the company. The company cannot remain solvent if it gives benefits greater than are paid for in the premiums. A few statistics will indicate the limitations on benefits that can be paid where premiums are low enough that the policy can be sold. Disability insurance should be regarded as protection against what might otherwise be a calamity. To go beyond that is inadvisable, as a few statistics will demonstrate. According to re-

liable statistics there are 662 cases of disability per 1,000 of population each year in the United States; that is, two out of every three are disabled, if by being disabled is meant that one or more days work is lost because of illness or injury. So in the figure 662 will be included everything causing any loss of time, whether for a single day or for an entire life time. Only 75 of the 662 disabilities per year result from accident. The remaining 587 are caused by sickness. Obviously any policy covering policyholders so completely that two out of every three would collect each year under their policies for disabilities ranging from one day to the entire lifetime would require such a prohibitive premium that not enough sales could be made to make the business succeed.

SOME PITFALLS IN SPECIAL POLICIES

Insurance is a highly competitive business. Occasionally insurance companies try to gain a competitive advantage by making their policies appear to offer more than they really do. They may promise complete protection from the first day of disability and then include exclusions of certain ailments from the coverage. They may permit cancellation of the policy or termination of it by refusing to renew the policy at the expiration of the time covered by the last premium paid. They may pay only while the person is totally disabled or continuously house confined. These mentioned limitations on liability of course do not exhaust the limitations that may be included in a policy which may overemphasize some desirable feature which is more than made up for by undesirable limitations and exclusions.

One of the means by which some companies try to meet competition is by claiming that they are giving group insurance to special classes, when in fact what they are offering does not constitute true group insurance. True disability group insurance is insurance which does not become effective until a certain percentage of the members of the group have subscribed for policies all of the same kind. Thus if a company were to write disability group insurance on the medical association it would be such insurance as would become effective only when some definite percentage of the whole association had subscribed for and been issued the same kind of policy—or, for convenience sake, had issued one master policy with certificates of interest to the individuals in that master policy.

There is a type of group insurance which is sometimes referred to as "franchise group insurance." A franchise, as a matter of law, is a privilege or right which may be granted to one or more but is not given to the whole public. For instance a policy might be specially worked out for members of the medical profession which other professions or the public at large could not obtain. The company giving the right or privilege—or in legalistic language, the franchise—would not give the same policy to those who were not in the group receiving the franchise from the company. Some insurance companies have attempted to meet competition by marking their regular policies as special policies for some group or other when the fact is that any other group or profession, or even any member of the public at large, could buy exactly the same policy for the same premium. Yet the idea that is implanted in the mind of the member of the profession who looks at an application blank with the words in large letters to the effect that the policy is one available only to those who are members of his particular profession is that he is getting something special—something better than the general public, or those not a member of his group, could get for the same money.

Still another of the means by which companies seek to make it appear that they are offering something better for a lower price than their competitors offer is to offer a franchise group policy declared to be non cancellable and renewable without the consent of the company, and then include in that policy exceptions under which all the policies issued to that franchise group may be cancelled or the right of renewal refused. Suppose you obtain a franchise group policy of that kind. The company may carry along and continue to renew the policy until the increase of the average age of those who have obtained such a policy brings the group into the place where there is a heavy cost in carrying the insurance further. Then the company may refuse to renew everybody in that group and all of them will have their disability insurance thereby terminated at a time when they have grown older, been afflicted by disease, and become uninsurable. Just when they need the insurance it may be cut off. This plan could be carried out only partially, by the company writing new policies for those who still continue as desirable risks and then cancelling all the original policies in the original franchise group.

NO ASSOCIATION INDORSEMENT OF ANY DISABILITY INSURANCE

Because of these elements which affect disability insurance—and similar elements of a like technical nature affecting all other types of insurance—the state association has never indorsed any particular policy nor any particular company, except with respect to malpractice insurance. On malpractice insurance the Committee on Insurance, with the help of insurance men and legal counsel, worked out the form of the policy, and the St. Paul Mercury Insurance Company agreed to issue policies in that form. The committee did not do this until after it had given opportunity to other companies to write the same policy and they had indicated that they were not interested in it.

No company or policy has been indorsed for disability insurance or any other type of insurance, with the exception just stated. If any indorsement were ever to be made by the association of any policy or company there is no doubt but what the program that would be followed by the state association in that event would be for the association to inform the members of their action, and not leave it as a matter upon which the profession would receive information only through the representatives of the insurance company.

CONCLUSION

This article has been written with the sole purpose of attempting to give to the members of the association at least enough understanding of disability insurance programs that they will realize that these problems fall within a specialized business where service of a professional nature should be had. Fortunately such service is generally available through your own locally established insurance agents who are making of their work a serious profession, or it may be obtained through legal counsel.

THE BROOKINGS INSTITUTE REPORT

The recent memorandum of the Brookings Institution of Washington is of significant importance. The conclusions reached by this independent group of investigators is of particular interest to the medical profession because it voices many of the conclusions that the profession has been advancing for a long time. In order that we can become familiar with these statements, they are here presented in full.

CONCLUSIONS

The conclusions based on this foundation are:

1. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogeneous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.

2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care.

3. The non whites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.

4. The advances in health among both the whites and the non whites that have been made in the United States in the past four decades do not suggest basic defects in the American system.

5. Although the statistics resulting from the administration of the Selective Service Act—the so-called draft statistics—have been widely used to show bad health among the American people and the need for revolutionary changes in arrangements for medical care of individuals, they are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole.

6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the Second World War.

7. The conditions in extremely poor rural areas that lack the resources to support adequate public services, such as health work, education, and highways cannot be satisfactorily solved by subsidies. This problem calls for a radically different approach, either bringing in new or improved eco-

nomic activities or getting the people to more favorable and administratively less expensive areas. This condition has been accentuated by the emigration of youth from these areas to urban communities.

8. The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthrophy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements.

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

12. The administration of compulsory insurance would require thousands of Government employees for accounting, auditing, and inspection and investigation.

13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency to insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.

14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.

15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (a) fee for service, (b) per capita, or (c) salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

RECOMMENDATIONS

1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Government administration. It seems highly improbable that this experimentation—possible under our Federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtless then be adopted with a great degree of unanimity. If compulsory insurance should be adopted now by a narrow vote in the Congress, thousands of persons who are opposed to it would start hostile to the whole undertaking.

2. For the time being the National Government and many of the State governments may well devote their resources and energies to:

(a) Research and developments in the fields of public health;

(b) Health education at the school level;

(c) Teaching of preventive medicine;

(d) Assisting in the acquisition of physical facilities and training of personnel;

(e) Providing systematic care for the indigent and the medically indigent. In some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and coordinated program.

3. From the standpoint of public relations, governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, state, and local voluntary organizations which have been able to enlist the active cooperation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are non medical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest, and cooperation of individuals, families, and local communities.

These recommendations are not widely at variance with those of the majority of the Committee on the Costs of Medical Care, arrived at in 1932 after a comprehensive study.

The years since 1932 have witnessed—

1. A great growth in voluntary insurance both for hospitalization and for medical services.

2. State experimentation with compulsory health insurance in Rhode Island and California.

3. A growing willingness on the part of practitioners to cooperate in the development of prepayment plans and other devices to enable patients who so desire to regularize their payments for medical care.

4. A profound change in the amount and distribution of the earnings of the American people. This change greatly reduces the number who cannot afford adequate medical care if they desire to purchase it.

The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the majority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to free policies and eventually retard medical progress.

NEWS FROM WASHINGTON

House Cuts Social Security Budget

Social Security Administration is a branch of the Federal Security Administration and as such has an appropriation of its own. The House severely cut the appropriation of the Social Security Administration, authorizing the transfer of many of its activities to the jurisdiction of the Federal Security Administrator. The budget for the Bureau of Research and Statistics was a particular object of discussion. It called for 54 positions at $229,830 and the House reduced it to $100,000, thereby requiring the reduction of the staff personnel from 50 to 20 employees. The Publications and Review Division and Informational Services of the Social Security Administration were also the object of severe criticism. The budget estimate for the two units called for 24 positions at $109,997, which the House reduced to $30,000. The Senate has not acted upon it as yet.

Selective Service Bills

The Selective Service bills have reached the floor of their respective Houses after weeks of committee study, S2655 and HR6401 now ready for action. Representative Anderson of California attempted to eliminate the drafting of medical and allied groups as a class, but was unsuccessful. Another attempt will be made on the floor of the House. The Senate bill contains the following language:

"(C) (1) Notwithstanding any other provision of this Act, the President is authorized, pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical and dental professions and allied specialist categories who have not attained the age of forty-five at the time of such call in such classifications as he shall determine. Persons in medical and dental categories shall be inducted in accordance with the following priorities:

"(First) Participants in the Army specialized training program or similar programs conducted by the Navy and persons who were deferred from training and service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and who have had no active service as commissioned officers exclusive of time spent as intern.

"(Second) Those who did not have active service during World War II.

"(Third) Those who served the least numbers of full months during World War II. Persons called hereunder shall be liable for induction in the armed forces for training and service for twenty-four consecutive months, in accordance with such procedures as the President shall prescribe.

"(2) This section provides for the following exemption: No physician who is established in the community where he resides or is a member of a reserve component shall be called for more than one month in any one calendar year if the local board objects, providing he did not participate in any Army or Navy training program or was not deferred for educational purposes and has not served as a commissioned officer for more than ninety days."

The National Health Assembly in Retrospect

From AMA headquarters comes the comment that the National Health Assembly held in Washington in May "seems to have caused about as much noise, nationally, as a ray of moonlight falling on a cup of custard." Marjorie Shearon, who was denied admission as a delegate but was given a pass as a member of the press, says the Assembly "developed into a cruel hoax" in which "the gullible, the trusting, and the cooperative were hoodwinked. The whole Assembly was a gigantic lobby for civil rights, legislation, compulsory insurance, and the rest of the President's program." Oscar R. Ewing's show cost the public $45,000 and according to George F. Lull, secretary of the AMA, "accomplished among other things a lot of talk." Everyone at AMA headquarters felt for weeks that the American Medical Asscіation would be the target for many a blistering attack, but this was not the case.

Quincy Howe's statement in his report of the assembly over the Columbia Broadcasting System is worthy of note. We quote:

"Some laymen may feel that the American Medical Association has been somewhat slow in coming around to health insurance and to the idea of government aid for health. But look at it from the doctor's point of view: Like all of us, doctors are creatures of habit, and they have learned their habits in about the hardest way there is. Just try to change some of your own habits. Try to stop smoking the way I did; or try pulling up stakes, try going to live in a new community, changing your profession—it isn't easy.

"Those of us who have been impatient with the American Medical Association for resisting change show a sad lack, I think, of understanding of human nature. Doctors have to make so many sacrifices. They submit themselves to so many disciplines, they are so overworked just keeping up with their own jobs that the wonder to me is that any of them have time for anything else. And it is only natural that those who do interest themselves in something beyond their engrossing daily tasks want to hold on to their own tried and tested way of doing things.

"That so many doctors not only have taken the time to work with the National Assembly but have shown themselves so cooperative, so understanding, so open-minded, seems to me the most promising and the most important development of this whole meeting."

Dr. Lull has this to say:

"Having witnessed the workings of the National Health Assembly first hand, I believe Mr. Ewing and his large staff are to be congratulated for their fairness and impartiality. Hundreds of mimeographed press releases were turned out by more than a score of people, but they were all factual and free from propaganda. Even experienced newspapermen remarked about the 'straight news' releases."

The action area of the Health and Medical Care Section of this second conference explored the following fields in family life: (1) Nutrition, (2) Medical Care and the Family Budget, (3) Education in Human Biology as a Basis of Healthy Family Life, (4) Preparation for Marriage, (5) Sterility and Fertility, (6) Health Factors in Pregnancy, (7) Health in Infancy, (8) Health in Preschool and School Years, (9) Health in Old Age, and (10) Accidents and Family Well-Being.

Under the section on Medical Care and the Family Budget, the committee discussed the wide variations

n income and spending habits among American amilies, the unpredictable character of illness, the ossibilities of prevention and control, and con-idered the merits of the various types of prepay-ient medical care plans. Careful attention was iven to the virtues of a national program, but reference was definitely expressed for promotion f the voluntary prepayment plan system. It as accepted that solution of the health problem onsists not only of discovery and removal of isease or disability but must provide for the well eing of the family, hence involving problems of utrition, housing, and social relations. This is very nteresting because of its conformity with the con-lusions reached by the National Health Assembly. inal reports of the Conference are being drafted nd will be available at a later date.

Health Program for Alaska

The House Appropriations Committee has desig-ated $700,000 to enable the Public Health Service o develop a program of disease control and sanita-ion in Alaska. The Armed Services are planning to end many men to Alaska in the near future, and he very high rate of tuberculosis and venereal isease makes it important that proper sanitary pre-autions be taken. It is proposed that the Public Health Service should follow the plan which has roved so effective in areas around other camps.

National Conference on Family Life

On Saturday, May 8, some nine hundred delegates o the National Conference on Family Life (White House Conference), representing many of the same rganizations as were registered at the National Health Assembly, closed their work. The theme of he Conference was that the family must be the basic nit in all of our programs, both national and local, nd ways must be devised (1) to make local citizens nore conscious of the needs and opportunities for etter family living in our American communities nd (2) to stimulate action at the local level.

While the delegates, with a few exceptions, were ifferent from those who attended the National Health Assembly, there were some who represented heir organizations in both conferences. For ex-mple, our representatives to the Health Section were Dr. James R. Miller and Mrs. Henrietta S. Kice, the president-elect of the National Woman's Auxiliary. Dr. Wingate Johnson was also a delegate but could not attend. Dr. Haven Emerson, who was chairman of one of the committees of the National Health Assembly, was chairman of the Health and Medical Care Section of the National Conference on Family Life.

New Bills Introduced

NATIONAL SOCIAL INSURANCE

S2422—By Mr. McGrath, of Rhode Island, April 1 (for himself, Mr. Wagner, and Mr. Murray).

HR6099—Mr. Dingell, of Michigan, April 1.

To provide for a national program of old-age, retirement, survivors, and permanent disability insurance. Referred to the Committee on Finance in the Senate and the Committee on Ways and Means in the House.

Comment: These bills are revisions of S1679 and HR4303. They proposed to raise the benefits allowed under the old-age security law.

INTEGRATION OF ARMED SERVICES

S2523—By Mr. Morse, of Oregon, April 20. Amends the National Security Act of 1947 to provide for a single executive department for the operation and administration of the Army, the Navy, and the Air Force; and to give the Secretary of Defense adequate power to enable him to formulate and place in operation integrated programs for the national security. Referred to the Committee on Armed Services.

MEDICAL SCHOLARSHIPS

S2588—By Mr. Thomas, of Utah, April 30. Amends the Public Health Service Act to provide grants and scholarships for medical education and grants for dental, nursing, and public health education, and for other purposes. Referred to the Committee on Labor and Public Welfare.

Comment: Appropriation of $18,000,000 is authorized for grants to schools of medicine for the fiscal year ending June 30, 1949; $20,000,000 for the next fiscal year; and for each fiscal year thereafter such sums as may be necessary. For schools of nursing, $15,000,000 is authorized for the first year and $18,000,000 for the second. $6,000,000 is authorized for grants to dental schools for the first year and $8,000,000 for the second. Postgraduate schools of public health are to receive $1,500,000 for the fiscal year 1949 and $2,000,000 the next year. Provision is also made for the Surgeon General to authorize

appropriations for construction of school buildings and other school facilities. Schools benefiting from these grants shall submit reports to the Surgeon General. The Surgeon General is also authorized to grant funds to the states to be used in providing scholarships at schools of medicine, nursing, dentistry, or postgraduate schools of public health. A system is also provided for the selection of not more than 600 persons for National Medical Scholarships, the acceptors agreeing to serve, upon completion of their undergraduate and graduate studies, one year for each two academic years during which they received the benefits of the scholarships.

IODIZED SALT

HR6080—By Mrs. Bolton, of Ohio, March 31. Amends the Federal Food, Drug, and Cosmetic Act so as to prohibit the movement in interstate commerce of salt, in certain containers and of certain crystal sizes, not having a prescribed content of iodides. Referred to the Committee on Interstate and Foreign Commerce.

SCIENCE FOUNDATION

HR6238—By Mr. Van Zandt, of Pennsylvania, April 14. To promote the progress of science; to advance the national health, prosperity, and welfare; to secure the national defense; and for other purposes. Referred to the Committee on Interstate and Foreign Commerce.

Comment: Another National Science Foundation Bill identical with HR6007.

SOCIAL SECURITY ACT AMENDMENTS

HR6279—By Mr. Dingell, of Michigan, April 20. Amends title II of the Social Security Act in order to reduce the qualifying age for old-age and survivors insurance benefits to sixty-two and to increase the monthly retirement benefits payable to a minimum of $100. Referred to the Committee on Ways and Means.

HOSPITAL CONSTRUCTION AMENDMENT

HR6339—By Mr. Wolverton, of New Jersey, April 26. Amends the provisions of title VI of the Public Health Service Act relating to standards of maintenance and operation for hospitals receiving aid under that title. Referred to the Committee on Interstate and Foreign Commerce.

Comment: Amends the Hospital Construction Act so as to discontinue benefits under the Act to any state which has not enacted the required enabling legislation, but provides that upon the enactment of such legislation its status may be restored.

DENTAL RESEARCH

HR6470—By Mr. Brehm, of Ohio, May 6. To provide for, foster, and aid in coordinating research relating to dental diseases and conditions; and for other purposes. Referred to the Committee on Interstate and Foreign Commerce.

Action on Bills

SOUTHERN EDUCATION AUTHORITY

HJRes.344—The House passed HJRes.344, a resolution which authorizes the establishment of a Southern Education Authority. It passed the House by a substantial vote, and the Senate, which has a resolution of its own, is debating the House bill instead.

SCIENCE FOUNDATION

S2385—The new National Science Foundation bill passed the Senate and has gone to the House. The House bill remains in committee.

WORLD HEALTH

HJRes.409—A new World Health Organization resolution was introduced by Congressman Judd to take the place of the one which the House Rules Committee failed to report. The new resolution specifies that the United States representative shall be a physician who has had "not less than ten years in active practice as a physician or surgeon." It further specifies that the annual appropriation shall not exceed $1,920,000 and that "nothing in the Constitution of the World Health Organization in any manner commits the United States to enact any specific legislative program regarding any matters referred to in said Constitution."

HEART RESEARCH

S2215—Passed the Senate on May 24. Similar bills in the House are still in committee.

Hearings

HEART BILLS

HR3762, HR5087, HR5159—The House Interstate and Foreign Commerce Committee held hearings on these bills on May 5 and 6. The AMA submitted a statement prepared by Dr. Edward Bortz approving the plan embodied in the bills, but suggesting that research of this character should be one

of the functions of the National Science Foundation when created.

VENEREAL DISEASE CONTROL

HR3934—This bill, asking authority for the continuation of Rapid Treatment Centers for Venereal Disease Control, was accorded a hearing by the House Committee on Interstate and Foreign Commerce on May 11.

Late Additions

SCHOLARSHIPS DISALLOWED

The supplementary appropriation for the Federal Security Administration was amended in the Senate by the addition of a clause providing that $132,000 of the total $13,000,000 appropriated originally might be diverted to payment of twenty-five four-year scholarships in medical schools for persons who would be willing to practice in areas where there might be an acute shortage of physicians, as, for instance, in the negro areas of the South, Spanish-American areas of the Southwest, or in areas where migrant laborers are located. The scholarships were to amount to $1,320 a year to cover tuition, books, and subsistence. When the bill went to conference, the House conferees objected to the amendment and it was defeated.

SENATE COMMITTEE TO STUDY HEALTH PROBLEMS

The Senate Committee on Labor and Public Welfare is directing its Subcommittee on Health (Senator Smith, Chairman) to continue its study of the health problems of the nation and be able to report on March 15, 1949. The Subcommittee is authorized to develop a research staff and to hold hearings. An amount of $10,000 from the contingent fund of the Senate is allowed to cover expenses. Because of this decision the Committee will not submit a report at this time on S1320 and S545.

Compulsory Attendance at Medical Meetings

The Indianapolis Medical Society on April 27 unanimously adopted the following statement of policy:

"We, the members of the Indianapolis Medical Society, do hereby resolve that the welfare of the medical profession, its scientific advancement and the furtherance of public interest are continuously being harmed by organizations which demand compulsory attendance of physicians at meetings.

"To this end we instruct our duly elected delegates to the Indiana State Medical Association to introduce proper measures at the next meeting of the House of Delegates to the effect that all organizations which require compulsory attendance at their meetings no longer be approved by the American Medical Association; and, we further instruct our delegates to use their utmost influence to obtain passage of such a resolution at the earliest opportunity before the House of Delegates of the American Medical Association.

"The Indianapolis Medical Society furthermore instructs its secretary to send a copy of this resolution to every component Medical Society in the United States."

THE DOCTOR'S OFFICE

Jerome S. Beloff, M.D., announces the opening of his office for the practice of diseases of infants and children at 8½ West Main Street, Meriden.

James C. Fox, Jr., M.D., announces the opening of his office for the practice of neurology at 56 Garden Street, Hartford.

William Glaser, M.D., announces the removal of his office for the practice of pediatrics to 1098 Chapel Street, New Haven.

Howard S. Morrow, M.D., announces the opening of his office for the practice of obstetrics and gynecology at 345 Main Street, Danbury.

John G. Rayner, M.D., announces the reopening of his office for the practice of surgery at 59 McKinley Avenue, Norwich.

Walter R. Van Tassel, M.D., announces the limiting of his practice to surgery, gynecology and obstetrics at 160 Post Road, Darien.

Charles E. Windus, M.D., announces the opening of his office for the practice of diseases of the ear, nose and throat at 321 Main Street, Bristol.

Mario H. Yannellio, M.D., announces the opening of his office for the general practice of medicine and surgery at 55 West Main Street, New Britain.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*

Egbert M. Andrews, Hartford
Joseph J. Bruno, New Haven
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Dr. Morrison New VA Consultant for Surgery

William Reid Morrison, internationally famous surgeon of Boston, has accepted the post of chief consultant for surgery of Veterans Administration. Dr. Morrison, one of the founders of the American Board of Surgery and for many years an outstanding teacher in medical schools, will devote a major portion of his time to the surgical problems of veterans.

He was born in Boston July 10, 1889, was graduated from Harvard College in 1910 and from the Harvard Medical School cum laude in 1913. He has been a teacher of anatomy at Harvard Medical School; instructor in surgery, Tufts College Medical School and assistant, associate and clinical professor of surgery, Boston University School of Medicine; surgeon-in-chief of the first surgical service at Boston City Hospital and associate chief examiner in surgery for the National Board of Medical Examiners at Boston City Hospital for many years.

Dr. Morrison has been a fellow of the American College of Surgeons for 25 years and is a founder of the American Board of Surgery.

New VA Hospitals for New York City and Boston

President Truman and the Federal Board of Hospitalization have approved the acquisition of 3 additional acres of land on the east side of Manhattan Island in New York City as a portion of the site for a new 1,000 bed VA general medical and surgical hospital. These additional 3 acres will be added to 3 acres previously approved for acquisition to form the total hospital site. More than 91,000 square feet of the area will be given to the Federal government by the City of New York. The remainder will be acquired by the government from private owners.

Approval also has been obtained for the acquisition of a new 15-acre site in Boston for a 1,000 bed VA general medical and surgical hospital. The new site is within a 3 mile radius of downtown Boston and within 1½ miles of Harvard Medical School.

Veterans in Hospitals

As of April 1948 there were 108,036 veterans in hospitals. Of this number in VA hospitals there were 30,650 with service-connected disabilities and 61,434 with non service-connected disabilities. In non VA hospitals there were 5,835 with service-connected disabilities and 8,892 with non service-connected disabilities. The remaining 1,225 comprised non veterans, patients temporarily hospitalized, and patients under observation.

World Health Organization to Begin Training Tuberculosis Fellows at Colorado Hospital

More graduate physicians from various countries will learn modern advanced techniques in United States hospitals and universities, thanks to the fellowship program which is part of WHO's campaign aiming at worldwide control of tuberculosis.

The first hospital in the United States to provide free instruction in methods of tuberculosis prevention, control, and treatment is the National Jewish Hospital at Denver, Colorado. This hospital will receive four WHO fellows appointed by the WHO Interim Commission from various countries in July 1, 1948. They will study at the hospital for a period of six months.

Beginning January 1, 1949 the WHO will send 12 similar fellows to the hospital annually. They will obtain their instruction not only in the hospital, but at the University of Colorado Medical School, Fitzsimmons General Hospital, and other institutions in Denver noted for successful techniques in tuberculosis treatment and control.

MILITARY BIOGRAPHIES (*Continued*)

These brief sketches of military experience of members of the Society have been compiled from data taken from questionnaires completed by each medical officer. Biographical material for some officers is lacking because questionnaires were not returned.

LTTLE, MERVYN H., Willimantic; b. 18; Harvard 1935; Navy—December 1941 Lt. (j.g.), Lt. June 15, 1942, L Comdr. March 1, 1944; Commander November 5, 1945; Service Terminated ember 19, 1945; Duty—Course Indtrial Hygiene and Toxicology, Cambge, Mass.; New Haven, Conn.; Newpt, R. I.; Crane, Ind.; Quonset Point, RI.

LTWIN, RALPH D., Bristol; b. 1911; Lg Island College of Medicine 1936; Any—May 1, 1942 Lt., Captain Septber 9, 1943; Service Terminated Mrch 13, 1946; Duty—School of Roentgology, Washington, D. C.; Lovell Cheral Hospital, Ft. Devens, Mass.; 3h General Hospital, Auckland, N. Z., Span, M. I.; 204th General Hospital, Cam, M. I. (Asiatic-Pacific Theatre of Cerations).

IGAN, WILLIAM J., New Haven.

INGO, AMERICO D., Portland (Ented service from Providence, R. I.); b911; Georgetown 1938; Army—April 1943 Lt., Captain December 1944; Svice Terminated March 13, 1946; Ity—Carlisle Barracks, Pa.; U. S. Army Hspital Ships and Transports—Africa, Sily, Italy, England, France; Awards—2ampaign stars.

IUDERBOUGH, HENRY, Watertown (ntered service from Englewood, N.]; b. 1906; Vermont 1938; Navy—Ivember 1, 1943 Lt., Lt. Comdr. Noember 1, 1945; Service Terminated bruary 23, 1946; Duty—Camp Elliott, (lif.; Bainbridge, Md.; 5th Marine vision, Iwo Jima—27th Marines—cupation of Japan (Asiatic-Pacific eatre of Operations).

)VETERE, A. ARTHUR, New Britain; 1909; George Washington 1935; my—March 6, 1941 Captain, Major cember 1943; Service Terminated May , 1945; Duty—Camp Lee, Va.; Camp lk, La.; New Orleans, La.; Ft. Knox, .

)WELL, W. HOLBROOK, JR., Hartd; b. 1909; Harvard 1937; Army Air —August 10, 1942 Lt., Captain February 1, 1943, Major February 1, 1944; Service Terminated September 27, 1945; Duty—Robins Fld., Ga.; Craig Fld., Ala.; Charleston, S. C.; Dyersburg, Tenn.; China Burma-India Theatre of Operations; School of Aviation Medicine, Randolph Fld., Tex.; Tactical Surgeons School, Orlando, Fla.; Westover Fld., Mass.; Awards—Soldiers Medal; 2 battle stars.

LUBCHANSKY, JACOB H., Uncasville; b. 1906; New York University 1933; Army—March 25, 1944 Lt., Captain September 1, 1945; Service Terminated September 5, 1946; Duty—Camp Chaffee, Ark.; Ft. Smith, Ark.; Ft. Devens, Mass.

LUKOSKI, WALTER A., Norwich; b. 1907; Georgetown 1932; Army—September 28, 1942 Lt., Captain March 1, 1944; Service Terminated November 4, 1945; Duty—Camp Pickett, Va.; Tidworth Garrison, England; XIX Dist. Hq.—119th General Hospital (European Theatre of Operations).

LUNDBORG, FRANCIS L., West Hartford; b. 1902; Yale 1930; Army—August 27, 1943 Captain; Service Terminated April 6, 1946; Duty—Carlisle Barracks, Pa.; Camp Shelby, Miss.; Camp Beauregard, La.; Camp Howze, Tex.; 252nd General Hospital—265th Med. Det.—Ord. Depot 0644 (European Theatre of Operations); Ft. Devens, Mass.

LUTZ, WALTER G., New Haven; b. 1912; Munich (Germany) 1936; Army—October 7, 1944 Lt., Captain October 1945, Major January 1947; Service Terminated September 7, 1947; Duty—Ft. Dix, N. J.; Battle Creek, Mich.; Phoenixville, Pa.; (Removed to New York, N. Y.).

LYDON, LAWRENCE G. M., New Haven; b. 1914; Yale 1940; Army—July 8, 1944 Lt., Captain 1945, Major 1946; Service Terminated July 10, 1947; Duty—Carlisle Barracks, Pa.; Letterman General Hospital, San Francisco, Calif.; 112th Evacuation Hospital; German Officers P.O.W. Camp; War Dept. Pers. Center; United States Military Academy, West Point, N. Y.

LYDDY, JOHN R., Bridgeport; b. 1919; New York University 1944; Navy—July 9, 1945 Lt. (j.g.); Service Terminated July 25, 1946; Duty—European Theatre of Operations; Asiatic-Pacific Thearte of Operations.

LYNCH, VINCENT A., Bridgeport (Entered service from Lincoln Park, Michigan); b. 1912; Jefferson 1938; Army—September 16, 1942 Lt., Captain April 23, 1943; Service Terminated February 1, 1946; Duty—Camp Hood, Tex.; Ft. Lewis, Wash.; 60th Sig. Bn., Lae, N. G.—Haramachida, Japan (Asiatic-Pacific Theatre of Operations).

LYON, HAROLD P., Hartford (Removed to Liberia, West Africa).

MACDOUGALL, A. DUNCAN, Groton; b. 1917; Cornell 1943; Army—December 31, 1943 Lt., Captain July 24, 1944; Service Terminated November 28, 1945; Duty—Carlisle Barracks, Pa.; Chemical Warfare School, Edgewood Arsenal, Md.; Ft. Devens, Mass.; 100th Infantry Division—Ft. Bragg, N. C.—France-Germany; Awards—Bronze star, Combat Medical Badge; European Theatre Ribbon w/2 battle stars; Unit Meritorious Service Plaque.

MACQUIGG. DAVID E., Meriden (Entered service from Columbus, Ohio); b. 1915; Ohio State 1943; Army—September 1944 Lt., Captain January 1946; Service Terminated December 1946; Duty—New Guinea; Netherlands East Indies; Philippines (Asiatic-Pacific Theatre of Operations).

MALONE, ROBERT F., Milford; b. 1917; Tufts 1943; Army—March 1944 Lt., Captain August 1945; Service Terminated May 1946; Duty—128th General Hospital—94th Replacement Bn. (European Theatre of Operations); Camp Lee, Va.

To be Continued

PROCEEDINGS — ANNUAL MEETING HOUSE OF DELEGATES

Hotel Stratfield, Bridgeport, Connecticut, April 27, 1948

Annual Meeting of the House of Delegates of The Connecticut State Medical Society was held at the Hotel Stratfield, Bridgeport, April 27, 1948, at 10:05 A. M. The meeting was called to order by President James R. Miller.

PRESIDENT MILLER: Gentlemen, the House of Delegates will come to order. You will give attention to the reading of the roll call.

Secretary Barker called the roll, and a quorum was declared present.

Secretary Barker assumed the chair while President Miller gave his report as follows:

Mr. Chairman, and Gentlemen of the House: I shall not give you a long report as President. I have a formal report to make to the members on Thursday noon, and I have poured into that report what I have to say on the subject of the proper relationship between government and medicine. This has been a busy year for me. I read a book once on the German War, written by a German military man who was chief of staff of a division at the front. He said that from that point of vantage he saw more of the war than any man above or below him. The high brass didn't get into the trenches, and the soldiers never got into the councils. He saw it from both ends With that background, his book was most interesting.

I have seen the problems of medicine in Connecticut from the point of view of the common soldier and of the brass hats. Sometimes the brass hats are supposed to have stuffed shirts. I assure you, however, that the price of shirts is too high to indulge in that variety.

As I have gone about the state to the county meetings, I have gained one impression which I would like to pass on to you, tempered with forebearance on your part—and lest I be thought to be critical, I would say that this is a bit of advice given on the basis of some experience—I have seen the county societies, which are the basic elements in our organized profession, consume endless time on insignificant details which don't interest members. I can tell you precisely the cost of the rental of this room, for example, because I heard it at your county medical meeting.

I don't suppose it interested anybody to know how much it cost to rent the room. I heard many similar details in the course of the county meetings. We must conduct our business better than that. When we ask a large group of doctors to leave their busy lives and come together, we must not defer until the end of the meeting the most important considerations which are under discussion, consuming the time of the first part of the meeting, when minds are fresh, with endless details which should be handled by committees.

I hope that the delegates will carry back to their county societies that message. We must put our house in order, and conduct our business, not high-handedly, nor in camera, but with dispatch, putting first things first. In my own county, for example, I was asked, during the past year to appear before the Board of Directors to discuss prepaid medical insurance. That certainly is one of our major problems. We met at five o'clock, and it was five minutes of seven, when the blood sugar was very low, when I was called upon to discuss the subject. Under those conditions, intelligent action is not forthcoming.

I am glad to say that our county has taken that matter seriously, and without suggestion on my part, I am glad to say has decided that meetings of their executive body are so important that they are going to meet for dinner and get up the blood sugar first, and discuss their important problems with deliberation. I commend it to you, that we get over the habit of transacting all of our business in the space of two or three hours, because it is too important.

Our nominating committees should have their slates prepared beforehand, and not meet five minutes before the County Medical Association. This is too important business to handle in a cavalier fashion.

We are going to have the pleasure of hearing from Dr. Bortz, president of the American Medical Association, and I anticipate we will have some of the flavor of experience which he has gained in travelling about the country. We have been exceptionally fortunate in having a man like Dr. Bortz to take the place of Olin West, who had to retire on account of illness.

I would request the members of the House of Delegates to apply their hearts unto wisdom, and to forego, as Benjamin Franklin once advised the members of the Constitutional Assembly, forego an overweening confidence, each in his own wisdom, for the common good. Thank you very much. (Applause.)

President Miller resumed the chair.

PRESIDENT MILLER: I will next call for the report of the Chairman of the Council.

Dr. Murdock read the report.

PRESIDENT MILLER: As the reports are presented, they will be received and placed on file, and any business arising from them will be brought up as desired, under the head of new or old business, as is appropriate. The Council's report is received and placed on file.

Next is the report of the Secretary.

Secretary Barker read his report.

PRESIDENT MILLER: The Secretary's report will be received and placed on file.

We next have the report of the Treasurer, Dr. Gibson.

TREASURER GIBSON: Mr. President and Members of the House of Delegates: The report of the Treasurer is on page 9 of your agenda. In addition, the report of the Auditors appears on pages 25 and 26 of the agenda. I should like to call your attention, first, to the fact that your organization during the year of 1947, lived within its budget, as you will see in the second column on page 25 where there is a comparison of budgeted expenses and actual expenses.

The 1947 budget indicated a probable excess of approximately $2,000 of income above expenditure. Actually, as a result of increased income and underspending the budget, a net favorable excess of approximately $3,800 resulted.

The budget for 1948 is very definitely more constricted, and on an estimated income of $68,945, the estimated expenditures are $68,000, in other words, a spread of only $945. And in these days when prices show little tendency to decline, it must be admitted that even with the most careful scrutiny by the finance committee, actually the Council, to remain within the budget will require delicate balancing.

Obviously, on the basis of current income, little thought can be given to the expansion of or the development of new activities of the society. I think you will be interested to know that for the year 1947, less than 1 per cent of the membership was delinquent in their dues. You will notice in the agenda a statement to the effect that by March 31 of this year over 75 per cent have paid dues for 1948. This figure now approximates 81.5 per cent, which means that prompt payment is being made of dues.

I call your attention to the development and enlargement of the auditor's report this year, which will give you a breakdown on the individual accounts and all other activities. You will find the amounts for which they were budgeted on page 25, and you will find, following that, the actual expenditures. We have been in the fortunate experience, practically since its beginning, to realize a profit to the society each year from the JOURNAL. The JOURNAL continues its excellence, as one of the outstanding journals of the country. But in order to maintain that high standard, it has been necessary in the year just past, 1947, to expend for the first time, actually more than the JOURNAL brought in as income. This was due, of course, largely to increased mechanical costs, and to increased labor costs.

While we have tried to anticipate this in the budget for 1948, there is some possibility that once again the amount budgeted will not meet the actual expenses of the JOURNAL.

I ask, when you have an opportunity, that you study carefully the breakdown of the various activities and organization and expenditures, as pointed out in the auditor's report. I think you will realize, if you digest those figures, that your society is in sound financial condition, but that financing necessarily at the present time is very close. Thank you. (Applause.)

PRESIDENT MILLER: There are no recommendations in this report. Will you take action on it? It is proper at this time.

The report of the Treasurer was accepted.

PRESIDENT MILLER: The report of the Delegates to the American Medical Association, Dr. Howard.

DR. HOWARD: Mr. President, the report of the Delegates to the American Medical Association has been published on pages 10 and 11 of the agenda. It hardly needs more comment, since the entire proceedings were published in the *Journal of the American Medical Association* of January 17 and January 24. However, there is one thing that I think should be stressed and brought to the attention of the House, and that is the recognition that is given to the State of Connecticut by the physicians throughout the country. As you will find in the agenda here, I mentioned the fact of Dr. Murdock's report on the nursing problem throughout the country, and I can assure you that it was received with considerable enthusiasm by the members of the House of Delegates of the American Medical Association. Dr. Murdock will give his final report at the next meeting in June.

Also, the activities of Dr. Barker and his particular Committee on Education were well recognized. Jim Miller, of course, being a Trustee of the American Medical Association, is thought very well of by the group. So we move about the country and attend these meetings, and we more and more realize that the Connecticut State Medical Society is well recognized and thought so much of by the men throughout the country.

PRESIDENT MILLER: The report of recognition of Connecticut would go incomplete if I didn't add that Joe Howard is president of the Association of Presidents of State Medical Societies, and will head that organization at its meeting in Chicago in June. This report will be accepted, then, and placed on file.

The report of the Committee on Medical Education and Licensure. This is an extremely important report. It is the lifeblood of every member practicing medicine in this state. You should all read it and understand it.

DR. MURDOCK: Mr. President, I don't think it requires any explanation. The report was compiled by Dr. Bartlett, the president, and by Dr. Barker. It covers the situation very thoroughly. There are no recommendations in the report, and I move its adoption, Mr. President.

The report was accepted.

PRESIDENT MILLER: The Committee on Public Policy and Legislation, Dr. Douglass. He has not arrived.

DR. BARKER: I move to accept the report, Mr. Chairman.

The motion was carried.

PRESIDENT MILLER: We will now have the report of the committee on National Legislation, Dr. Stringfield.

DR. STRINGFIELD: Mr. Chairman, I would like to augment the part of the report which pertains to S-1290, and suggest that this body approve the report before the Committee on Labor and Public Welfare, made by Dr. James R. Miller in behalf of the American Medical Association, in toto, as it expresses, I think, the feeling of all of us pertaining to this particular bill. Also, I would like to call to the attention of the House a memorandum which was sent by our secretary to our Representatives relative to the Andrews bill, which calls for selective service on the part of physicians.

This memorandum reads as follows: "The Connecticut State Medical Society wishes to direct your especial attention and opposition to the provision in the Andrews Bill, to reactiviate the selective service which authorizes special calls for physicians, dentists, and veterinarians up to 45 years of age. Our opposition to this proposal is on the ground that it is unnecessary, in view of the record of medicine in World War II, in supplying needed medical personnel. Further, we believe it is discriminatory in that the needed scientific and technical personnel is not subject to similar call, and that it reflects on the patriotism of

physicians by inferring they will not volunteer in our country's defense."

President Miller: With regard to the report itself, that will be received and placed on file, and would you vote on its adoption as presented? The motion is on the adoption of the report as originally presented.

The report was accepted.

President Miller: Would you like to bring up, Dr. Stringfield, the matters for decision at a latter date, under new business?

Dr. Stringfield: Yes.

President Miller: Thank you. The committee on hospitals, Dr. Nesbit. (Not present.)

I will comment briefly, on extending the remarks of the Secretary, that one would gather that we had no problems in the hospital field. There certainly is need for an active committee to work on this subject.

Next is the report of the Committee on Industrial Health, Dr. Yeager.

Dr. Yeager: The report of the Committee on Industrial health appears and is submitted, on page 13 and 14.

This report was accepted.

President Miller: The Committee on Prepaid Medical Service. Dr. Barker, will you take the chair?

Dr. Barker assumed the chair.

Dr. Miller: The report of the Committee on Prepaid Medical Service has been presented to the delegates, has been presented to meetings and officers of the various counties, and has been discussed at length at various county association meetings. I think it would be appropriate if this committee report was received and placed on file, and the discussion of the business under it taken up under old business.

Dr. Howard: I so move.

The motion was seconded.

Chairman Barker: Motion made and seconded that the recommendations made in the report of the Committee on Prepaid Medical Service be deferred until later in the day, taken up under Item 4, Recommendations and Committee Reports. Will you discuss this motion? If not, those in favor will say aye. Those opposed no. The motion is carried.

President Miller resumed the chair.

President Miller: The committee on Public Relations, Dr. Burlingame.

Dr. Burlingame: Once more it is our privilege to submit a report that appears on page 16, and continues on to page 17, which was written by Mr. Burch, and is a product of Mr. Burch's effort. Your Committee on Public Relations is most fortunate in having such a capable executive officer who relieves the committee of most of its duties. I would like to add once more my words of commendation. I think his report is quite inadequate to set forth the intangible things which a good public relations officer initiates and carries on. I submit that special commendation for Mr. Burch.

This report was accepted.

The report of the Committee on Public Health, the Committee on Tumor Study, the Committee on Honorary Members and Degrees, and the Committee on the Clinic Congress were then accepted as printed in the agenda.

President Miller: The report of the Board of Trustee of the Building Fund, Dr. Gold.

Dr Gold: Mr. President and Members of the House o Delegates: During the past year, your trustees have realize that the funds coming in for the building fund were ver slow. Fifty-two per cent of the membership have n subscribed. You will find the report on page 19. Knowin the crowded conditions of the state office, we finally d cided to recommend to the council that they take the mone that we have and ask the Society to subsidize to the amou of $15,000, which will make $75,000, and we would proce to build a building for that amount, all costs included i that $75,000.

The council accepted our recommendation, and yo will find our report on page 19. The plans are about read and as soon as the House of Delegates has passed upon ou recommendation, we propose to continue, and within a shor time a building will be started so that within 6 or 9 month we hope to be in the new quarters. I move the adoptio of the report.

The report was then accepted.

President Miller: Committee on Cooperation with th Yale School of Medicine, Dr. Murdock.

Dr. Murdock: Mr. President and Members of the Hous of Delegates: The report is printed on page 19 of th agenda. There are no recommendations, and I move th adoption of the report. Motion was passed.

President Miller: The Committee to Study the Organi zation and Objectives of the Society, Dr. Courtney Bishop

Dr. Bishop read his report.

President Miller: If the Chair might be permitted t remark, that is a constitutional convention in itself in th space of one report. I would like to call for a report o the Committee for the Medical Care of Veterans, Dr Rentsch.

Dr. Rentsch: This report is printed on page 19. I want to make sure that Mr. Burch is credited for helping this committee in many and various ways, and we would not like to get along without Jim's help. It is an expanding problem, as the report states. If we are going to fight another war, we had better try to get this one out of our systems as much as we can. But it will be with us always.

On the next to the last paragraph there is mentioned a grievance committee, and note is made that very few or no grievances have been brought forward. Gentlemen, this is our baby. We must take care of this situation. If it is not going right, let us hear from you. I move the adoption of the report.

Motion passed.

President Miller: I neglected to say that Dr. Bishop's committee report will be received, and the actions recommended will be considered under Item 4 of the agenda.

The Committee on Rural Medical Service, Dr. Gardiner.

This report was accepted.

President Miller: Committee on Drug Addiction, Dr. Foster.

Dr. Foster: The report of this committee is published pages 20 and 21 of the agenda. I would just like to ll your attention to one or two of the items. As you obably know, the law forbids pharmacists to fill telephone ders for narcotics. The State Department of Health is nning to enforce the law throughout the state. That is mething that is going to jolt all of us. It does seem some vision might be made to provide for emergencies, but to event the abuse of telephone prescribing. The State Dertment of Health is studying this problem, and we hope me solution can be reached.

The question of the filling of prescriptions for barbiturates apparently not satisfactory to the State Department of ealth, and they are working on a solution to that. The oblem of alcoholism is being taken up by the State Alcolic Commission, and one member of this commission is member of our committee. It seems to us that this mmittee on Drug Addiction would be a suitable contact ison between the State Alcoholic Commission and our ate Medical Society, and I would recommend that approval be given to this committee, to be continued, and to t as the contact with the State Alcoholic Commission.

President Miller: Will you bring up your recommendans at the appropriate time? Is there a motion to adopt is report?

Motion passed.

President Miller: Conference Committee with the Concticut Pharmaceutical Association, Dr. Salter.

This report was adopted.

President Miller: Committee on Statewide Blood and asma Bank, Dr. Kendall.

This report was adopted.

Secretary Barker: I think if Dr. Kendall was here he ould tell you what I am going to, and I believe he would e to have me tell you now. It seems quite likely that the merican Red Cross, which is developing a community ood bank, as you know, in several parts of the country—ey now have three or four of them in operation—are now ry favorably disposed to developing their first statewide nk in Connecticut. It is likely that within the next two three weeks the first steps toward the development of at will take place. How soon it will actually be in eration is anyone's guess. But the important people in e blood bank program for the Red Cross have been here out two weeks, Admiral MacIntyre, Dr. Smith, and Dr. iamond, and it seems at last that we are going to get mewhere with a matter which we have been working on w for almost since the war was over.

President Miller: Thank you, Dr. Barker. The Committee to Study Maternal Mortality and Morbidity, Dr. oward.

Dr. Howard: The report of the Committee to Study laternal Moratlity and Morbidity is published on page 22 the agenda, and I move its adoption.

Motion passed.

President Miller: Advisory Committee to the Women's uxiliary, Dr. Gilman.

This report was adopted.

President Miller: Delegates to the Council of New England State Medical Societies, Dr. Gibson.

Dr. Gibson: The report of the delegates is published on page 23 of the agenda. I move the adoption of the report.

Motion carried.

President Miller: Committee representing the Society on the Board of Directors of Connecticut Hospital Service, Dr. Landry.

This report was adopted.

President Miller: Committee to Study the Workmen's Compensation Laws, Thomas Soltz.

Dr. Soltz: The report of the Committee to Study the Workmen's Compensation Laws, is published on page 23, and I move its adoption.

President Miller: I should rule, Dr. Soltz, unless overruled, that this would be received, and the items in the committee report which call for action will be brought up under Item No. 4.

President Miller: Committee on the Chronically Ill, Dr. Wulp.

This report was adopted.

President Miller: Liaison Committee with the Yale Institute of Occupational Medicine and Hygiene, Dr. Murdock.

Dr. Murdock: Mr. President, and Gentlemen of the House of Delegates: There are no recommendations in the report, and I move its adoption as printed on page 24.

Motion carried.

President Miller: Next is the report of the Committee to Study the Medical Examiner System in Connecticut, Dr. Brae Rafferty.

Dr. Rafferty: No report.

President Miller: The Special Rediological Committee, Dr. Ogden.

This report was adopted.

President Miller: On the next page, page 4 of the agenda, are the recommendations of the council. Item No. 1 is Revision of Article X, Section 3, Paragraph 2, of the By-Laws of the Society. I will ask the Secretary to read this.

Secretary Barker: "The Council recommends to the House of Delegates that paragraph 2 of Section 3, Article X, be deleted in its entirety and that the following be substituted therefor:

"Par. 2. The Council shall nominate to the House of Delegates each year a Committee on Postgraduate Education of not less than seven members and name its chairman. The purposes of the committee shall be to plan and make available programs of postgraduate education in medicine, to arrange and conduct the annual Clinical Congress of the Society and to cooperate with university and other agencies for the extension of postgraduate education of physicians."

Mr. Chairman, I move the adoption of the resolution.

The motion was seconded.

President Miller: You have heard the motion made and seconded. Any comments?

Dr. Foster: What is the present by-law?

Secretary Barker: It relates to the Committee on the Clinical Congress only. It has no other purpose except to operate the Clinical Congress.

Dr. Foster: Therefore, this will expand that particular committee?

Secretary Barker: Yes, and it provides for a new method of appointment, and a new character of appointment, really.

President Miller: Would the members like the old by-law read, or is that understood?

Dr. Foster: Is there any way by which this committee is made continuous, or just annual election? Shouldn't there be some way in which it would be made self-continuing?

President Miller: I might comment that our experience with continuing committees is not always happy. Members can be continued when found useful, and can be discontinued when not found useful. The question is before you. All in favor say aye. Contrary? Carried.

Item No. 2, Proposal from the Board of Trustees of the Building Fund. I will ask the Secretary to read that.

Secretary Barker: "The Council has received a proposal from the Board of Trustees of the Building Fund that the Building Committee of the Board be authorized to have new plans prepared for a building for the Society's use, the cost of which is not to exceed $75,000 including all architects' fees and incidental charges and that the Council be asked to make available to the Board of Trustees a sum not to exceed $15,000 from the surplus funds of the Society for the purpose of supplementing the money now in the Building Fund so that the building can be constructed without further delay and it was also proposed that the Board of Trustees continue to solicit funds to repay the amount advanced to the Building Fund from the Society's surplus.

"The Council sought legal advice concerning the propriety of the Council taking such a step without approval by the House of Delegates and that advice is to the effect that approval of the House of Delegates should be had before the request of the Board of Trustees of the Building Fund be concurred in.

"Therefore, the Council recommends to the House of Delegates that a sum not to exceed $15,000 be made available to the Trustees of the Building Fund to be added to the money now available in the Building Fund which has been collected for the specific purpose of constructing a building for the Society. This allotment from the general funds of the Society is to be made to the Trustees of the Building Fund contingent upon the construction of the building for the Society's use for a sum not to exceed $75,000 and further agreement by the Board of Trustees of the Building Fund that it shall continue the solicitation of funds for the building and the ultimate repayment therefrom to the general funds and in no case is this amount to exceed $15,000."

This resolution was passed.

President Miller: Item No. 3, Election of Officers and Committees. The Secretary will continue.

Secretary Barker: "The Council, serving as a nominating committee for the Society, presents the following nominations for officers for the year 1948-1949:

President-elect, Dr. Charles H. Sprague of Bridgeport.

First Vice-President, Dr. Moses Margolick of Putnam.

Second Vice-President, Dr. Jessie Fisher of Middletow

Treasurer, Dr. Cole B. Gibson of Meriden.

Secretary, Dr. Creighton Barker of New Haven.

Editor of the Journal, Dr. Stanley B. Weld of Hartfor

Delegates and Alternates to the American Medical Assoc ation:

Dr. Joseph H. Howard of Bridgeport with Dr. Oliver I Stringfield of Stamford as alternate, and Dr. Creighto Barker with Dr. W. Holbrook Lowell of Hartford as alter nate.

These officers were duly elected by ballot.

The following committee members were then duly electe by ballot:

To the Program Committee for 3 years, Dr. Harris B Shumacker of New Haven.

To the Editorial Board for 4 years, Dr. Frank S. Jone of Hartford.

Secretary Barker: Mr. Chairman, it is customary o these committees, which are numerous, not to read them off. However, the nominations on the Clinical Congress d not appear on your agenda, because it was anticipated tha the amendment to the by-laws which you have just passed might be passed. Therefore, the council nominates for the new committee on Postgraduate Education: Harold A Bergendahl, Norwich; Courtney C. Bishop, New Haven Chairman; Bliss B. Clark, New Britain; Harvey B. Goddard East Hartford; John C. Leonard; Herbert Thoms, New Haven; William R. Willard, New Haven; Associate Member, C. N. H. Long, New Haven.

The members of the new Committee on Postgraduate Medicine were duly elected by ballot.

Secretary Barker: Mr. Chairman, the Committee on Public Policy and Legislation is before the delegates.

This committee was duly elected by ballot.

Secretary Barker: I shall save you from embarrassment. I shall nominate you to be a member of the Committee on Honorary Members and Degrees.

This committee was duly elected by ballot.

Secretary Barker: The Committee on Medical Education and Medical Examination, which is the Connecticut Medical Examining Board, one member for a term of 5 years, commencing January 1, 1949, to succeed Thomas P. Murdock, Dr. John H. Bumstead. I may say that the Society is given, under the medical practice in Connecticut, the opportunity of making a single nomination to the Governor. We are not required to nominate more than one person, and we never have nominated more than one person at a time. Up to this moment, the Governor has always appointed that single nominee that the Society has presented.

The nominee at this time is Dr. Bumstead, to succeed Dr. Murdock. I can't let this moment go by without returning across the net, the orchids which Dr. Murdock has so kindly placed upon my bosom. I tried to talk him out of going off the Medical Examining Board. Perhaps you will remember that I am the Secretary and Office Boy of

he Examining Board. He said he had it long enough, and e was getting tired and wanted to do something else. But will be difficult to find a person who has given so much o the process and the philosophy of medical licensure as Dr. Murdock has given in this state.

Dr. Bumstead was nominated and duly elected by ballot.

Dr. Davis: Mr. President, I move the House of Delegates xtend a vote of thanks to Dr. Murdock in behalf of the ommittee.

This motion was passed.

Secretary Barker: Two members of the Committee on Hospitals, Dr. Atkins, of Waterbury, and Dr. Phelps, of Hartford.

These were duly elected by ballot.

President Miller: The other committees can be acted n en masse, if you wish. They are large committees. What s your pleasure? Let us consider, for a moment, the committee on Indutsrial Health. Are there any other nominations that you would like to have on this committee? It as been, I know, over the years, the desire of the council o place on these large committees, all who have interest nd capacity. The Committee on Public Health, any suggestions there? The Committee on Public Relations. The Committee on Tumor Study. We soon will have the whole Society on the Committee on Tumor Study.

Dr. Soltz: I would suggest the addition of the name of Dr. George Cheney, who is in charge of the Tumor Clinic.

President Miller: You nominate Dr. George Cheney for n addition to the Committee on Tumor Study?

Dr. Soltz: Yes.

The motion was seconded.

President Miller: Are there any other nominations? If ot, how will you dispose of these committees?

Dr. Rentsch: Gentlemen, I would like to nominate on hat Committee on Tumor Study Dr. Oughterson, if his ame is not on here.

President Miller: Dr. Ashley Oughterson.

Dr. Rentsch: That's right.

The nomination was seconded.

President Miller: Are there any other additions? If not, will you dispose of these committees?

Dr. Burlingame: I move that the nominations be closed nd that the Secretary cast a single ballot for the entire list, ncluding that of delegates to the state and professional ocieties.

President Miller: Down to Item 4 on the agenda.

Dr. Burlingame: That is correct.

The motion was seconded.

President Miller: Is that understood? Any comments? Those in favor say aye. Contrary? It is carried.

Dr. Murdock: Mr. President, may I suggest that the genda be interrupted at this minute, and the two delegates from New York State, Dr. Edward Cunniffe and Dr. Walter Anderton be presented to the house. (Applause.)

Dr. Edward Cunniffe: Mr. President, Member of the House of Delegates of the Connecticut State Society: I am very glad to come here and visit this society. Of course, I know so many friends who are members. Some I met as students, some I met as internes, and many I met in the House of Delegates of the American Medical Association, where I have had occasion to observe and to respect their good judgment, where I have had an opportunity to note their fine contributions to the welfare of medicine.

I am very happy to come here to see how well organized a machine can be, as I happened to mention last year. It went along so well that when I went back to New York and gave them advice, they haven't suffered any defeats since, and O'Dwyer is still Mayor.

I am glad to come here today because I have a specialist here with me who accompanied me here. You know that is one of the great dangers and one of the things that concern us in medicine, the growth of specialism. It has gotten now so that everybody talks about it. A man told me the other who was an old man who practiced in a country town. He was the only doctor. He practiced there for years, and the people loved him. He thought it was time to retire, and he heard that a young doctor was coming to town. When the young doctor came to town, he thought that he would go and visit him and welcome him.

He said, "You will like it here. It is a nice life. Of course, you will be put out sometimes, you will have to leave dinner, and probably have to call off some engagement with your wife, but you will like it. You will get to like the people, and they appreciate it. They give you a great deal of respect, you know." The young fellow said, "Oh, I am not going to do that kind of practice. You know, I am a specialist." The old man was a little surprised, and he finally said, "You are a specialist?" The young man replied, "Yes."

The old doctor said, "I suppose you are an eye, ear, nose, and throat specialist?" "Oh, no," the boy said, "I only specialize on the nose." The old man looked at him for a minute and said, "Well, you don't mind if I ask you a question?" He said, "Oh, no." And the old doctor said, "Well, I would just like to know which nostril."

I have a specialist with me who is a specialist in visiting state conventions, and he is going to make the speech for the New York representatives. But I want to just say one word, a word in a serious way. This idea of the growth of specialties is causing a great deal of alarm, and I think we had better take it in hand to do something about it, because if we do not furnish general practitioners the osteopaths will, or some other group, and they will have legislatures to empower them to do it, and we will have a great deal of cheap medicine. So we must find some way to make medicine attractive to general practitioners, in order to supply this country. There is one other thing that bothers me today, and then I am through, before Dr. Anderton no doubt will make a splendid speech, and that is that I am very much concerned about the principles of ethics, and the observance of the principles of ethics by the physicians of our country. You know, if you look back over the history, you will find a great tradition in medicine, and I think it is greatly to their credit. It redounds to them, the way in which the American physician has read the principles of ethics and has conducted his professional life in accordance with them. That is one of the

great things that has brought the profession to the point that is so highly respected by the American people today.

I think that has been well worked upon; that has been the work upon which we have developed our success. We are now having in legislatures in some of our states, particularly my own, bills passed which allowed certain groups to split fees. Now, you know that the splitting of fees has always been frowned on by the American Medical Association. As a matter of fact, the principle says that splitting of fees in any form, shape or manner is unethical. And even if it is legal, it is still unethical. I think we want to remember that even though a thing is permitted by law, it is not necessarily permitted by the American Medical Association.

Consequently, I feel very strongly in this, because we are just about revising the principles of ethics, and we are having certain committees report on investigations in regard to group practice. Group practice is the practice which probably lends itself to this law-making more than anything else, and I think we must be very careful, because if we lower the standards of the principles of ethics of our country, I think we will suffer for it.

Now, I am sorry to add a kind of a sour note, and it is a sour note, because I am very much interested and very much fearful of the way that we may go, unless we go with great caution. I want to say that I regret very much that I wasn't here earlier, because I would like to have seen more. In fact, I like to visit you and see the whole thing, because I know you put a great show on up here. And again, I know that your deliberations are very fine, and I know that you always keep in mind the thing that you were urged to do when you first joined the practice of medicine, and that is to uphold the dignity, to exhalt its standards, and to extend and expand its sphere of usefulness. Thank you very much. (Applause.)

President Miller: I think there may be one or two in the audience who do not realize that Dr. Cunniffe, who just spoke to you, is the Chief Justice of the Supreme Court of Medicine. He is Chairman of the Judicial Council of the American Medical Association. That means that if you get in trouble, and your own council doesn't treat you right, and you appeal to the American Medical Association, you will appear before his board. So that what he has told you comes out of a wealth of experience and deep concern.

We will now hear from Dr. Walter Anderton. (Applause.) Dr. Anderton is the Secretary of the Medical Society of the State of New York, and I met him often in the House of Delegates of the A.M.A.

Dr. Walter Anderton: Ladies and Gentlemen, Mr. President, Mr. Secretary: Driving down here this morning with Dr. Cunniffe, he asked me if I had a speech prepared, and I said, "Why, not at all. I am going to get up first and say that I brought you with me, and that is all that is necessary." You know, Dr. Cunniffe is one of the finest and readiest at making a good speech, as you have already learned.

However, it is my privilege to bring you the greetings from the Medical Society of the State of New York, and to express our appreciation in being invited to your meeting again. We always look to your body, we follow its deliberations. We admire your members, not only here, bu for their work in and for the American Medical Associa tion. We know that what comes out of the House of Dele gates of the Connecticut State Medical Society is for th best interests of the public and the profession. I would like to tell you a little story off the record.

Dr. Anderton spoke off the record.

President Miller: We have other representatives here From Rhode Island, we have Dr. Elihu Wing.

Dr. Elihu Wing: Mr. President and Officers and Delegates to the Connecticut State Medical Society: I am sure it is always a joy to come back to Connecticut, where I spent several years, not as a practitioner. I came near being one here. I want to bring you the greetings of our State Society, and their good wishes for your meeting; and also to welcome you to Rhode Island at our annual meeting, which I think is May 12 and 13. The small State of Rhode Island and Connecticut have long had very cordial relations, and have cooperated in the solution of problems that we have had together, not between us, but some of the big problems that we have faced.

I think it is this spirit between the State Medical Societies and the new England Council, which is going to do a great deal for the furthering of the cause of good medicine and extending public relations. I want to congratulate your very able President in the national recognition which he has had, and that splendid talk he gave in Washington. I am sure we were given a great deal of pleasure in reading it.

I am not a Walter Winchell or any of that group, but I would prophesy that he is one of our coming presidents of our American Medical Association. Thank you very much. (Applause.)

President Miller: I think I will have to stop introducing foreigners at this moment. They might get me into trouble. I hope they are false prophets, between you and me. From Rhode Island also, we have Dr. Daniel Trappoli. (Applause.)

Dr. Daniel Trappoli: Mr. President, Mr. Secretary, and Delegates: I join with Dr. Wing in extending the greetings of the Rhode Island Medical Society to the Connecticut State Medical Society. I had a very delightful time this morning. I was thoroughly impressed with the thoroughness and dispatch with which you conducted your meeting, and I hope that I have picked up a few points for our society at home. Thank you. (Applause.)

President Miller: All the way from the State of Maine, Dr. Ferguson is with us. We are glad to have you, sir.

Dr. Ferguson: It is a pleasure to bring the greetings of the Maine Medical Association to your Connecticut Association. It is a particular pleasure for me to be here. I also bring the regrets of Dr. Marshall, who is unable to be here. I have looked forward to your clinical sessions, and I feel that I have continued my education with the prompt and efficient way you have conducted your business. (Applause.)

President Miller: Thank you, Dr. Ferguson. I am very glad that our delegates from other states have had this opportunity before lunch. Are there delegates from Massachusetts or Vermont or New Hampshire? I know that you will extend the hand of welcome to these visitors from

over the borders during the luncheon hour, and I hope they will be able to stay with us during the session.

Shall we take up first the recommendations that have come up in the various officers' reports? Dr. Barker has some of them.

SECRETARY BARKER: In the report of the chairman of the Council, Dr. Murdock, he recommended that the House of Delegates approve the creation of a Conference Committee with the hospital association and the Nurses Association, each of these organizations, including the State Medical Society, to have three members on such a Conference Committee. Mr. Chairman, I move the adoption of this recommendation.

This recommendation was adopted.

SECRETARY BARKER: In the report of the Secretary, there were five recommendations. The first was to establish a Conference Committee with representatives of the Connecticut Hospital Association. This may appear to you to be a duplication of the recommendation which was just adopted. On the other hand, I do not think that it is. We already have a committee on hospitals, but the proposal here is that his committee on hospitals re-establish the custom of conferring with the Board of Trustees of the Connecticut Hospital Association. Mr. Chairman, I move the adoption of this recommendation.

This recommendation was adopted.

SECRETARY BARKER: That this House of Delegates request the Committee on Tumor Study to develop a long-range plan for the cancer program in Connecticut, in consultation with other agencies interested in the cancer field. I move the adoption of this recommendation, Mr. Chairman.

Recommendation adopted.

SECRETARY BARKER: Committee on Honorary Members and Degrees, to outline and submit to the council a plan for appropriate recognition of members of fifty years standing. I move the adoption of this recommendation.

Recommendation adopted.

SECRETARY BARKER: Authorize the council to take all necessary steps in the defense program, and to appoint a committee on Emergency Medical Service, to cooperate with public and private agencies in this field. I move the adoption of this resolution.

Resolution adopted.

SECRETARY BARKER: There is one recommendation from the Committee on National Legislation, but I don't have it. Dr. Stringfield is here.

PRESIDENT MILLER: Dr. Stringfield, do you have a recommendation to make?

DR. STRINGFIELD: I have two recommendations, Mr. Chairman. One was relative to Senate Bill 1290. That is the School Health Bill. I am sure that all the members of the Committee on National Legislation will agree that the testimony given by Dr. Miller in Washington before the Senate committee, in behalf of the American Medical Association, will meet with our approval. The main point about it is that this bill calls for the advancement of its program by proposing to provide for the general welfare by enabling the several states to make more adequate provision for the health of school children through the development of school health services for the prevention, diagnosis, and treatment of physical and mental defects in children. Dr. Miller has taken up all of the detailed objections to this particular bill and has presented it, and it meets, I am certain, with the approval of the committee. I would like to propose that this body endorse Dr. Miller's testimony before the Senate Committee on Labor and Education.

Motion carried.

DR STRINGFIELD: The second item pertains to the Andrews Bill, which, as you know, provides that physicians and dentists and veterinarians can be activated up to 45 years of age. Dr. Barker sent the following resolution to our representatives: "The Connecticut State Medical Society wishes to direct your special attention and opposition to the provision in the Andrews Bill to reactivate the Selective Service, which authorizes special calls for physicians, dentists, and veterinarians up to 45 years of age. Our opposition to this proposal is on the ground that it is unnecessary, in view of the record of medicine in world War II, in supplying needed medical personnel. Further, we believe it is discriminatory in that other needed scientific and technical personnel is not subject to call, and that it reflects on the patriotism of the physicians by inferring that they will not volunteer in our country's defense."

I would like to have this body endorse that.

The motion was seconded.

PRESIDENT MILLER: You have heard the motion made and seconded. Will you comment?

DR. BUCKHOUT: Mr. President, I wonder why it is possible that this thing ever came up. It may not be relevant to this motion at all, but why did they pick on the medical profession? Why did they choose to decide that the medical profession should be handled this way, and why did they leave a law out, which they brought in during the war, including all other groups? Is there anything behind this that we ought to know?

Certainly, we got in the last one. There wasn't any argument about it. And I don't think there was very much pressure put behind those who got in. Is there anything behind that, Dr. Barker?

Secretary Barker spoke off the record.

PRESIDENT MILLER: I might comment on this, that the point of view of the American Medical Association was presented at the hearing during the past week. It was contemplated that the hearings would have finished yesterday. I have been busy on other things, and have not followed it closely. But I know that the point of view of the American Medical Association was to have been very ably presented to the committee. One suggestion only I made in Washington the other day, and that is that if the law stayed at the ages of 19 to 25, it might make liberal use of the contract surgeon and hire their doctor work done as they hire their carpenters and plumbers and everybody else. It would certainly take a great load off the uniformed servicemen. All of the work around camps, for example, might well be done by contract surgeons. We have contract surgeons by the thousands at the present time in the Veterans Administration on part-time. They don't have to be uniformed, processed and sent to camp. But I think that probably is too sensible a suggestion to be carried into effect.

Is there any further discussion on that? Those in favor of the question say aye. Contrary? It is carried.

Secretary Barker: Dr. Foster had an item on narcotics.

Dr. Foster: I would like the approval of the Medical Society that the Committee on Drug Addiction include the study of alcoholism, and be the official contact between the society and the State Alcoholic Commission.

This motion was carried.

We haven't heard yet from the Editor of the Journal. Dr. Thoms is here. Will you say something about the Journal?

Dr. Thoms: I don't know what to say about the Journal at this point. The Journal speaks for itself.

President Miller: There is a formal report before us in the agenda.

Dr. Thoms: Yes, there is. We are making a very definite effort to carry out some of the recommendations of the committee already, with more clinical articles. We are introducing in the May number a new section, which we copied somewhat from *New York Medicine*, on clinical medicine, that is, progress of clinical medicine. It is sort of summaries, to be written by our own members. I am very glad to say that we have had a splendid response from everybody who has been called upon throughout the state to do that work for us.

President Miller: It would be in order, then, to adopt the report of the Editor of the Journal.

The report was adopted.

Dr. Soltz: I think there is a little misunderstanding here. I said a recommendation was made in our committee. The recommendation is not made to this body. It stated that inasmuch as the compensation laws were enacted for the benefit of injured workmen, and since physicians are directly concerned with the problem of providing the best medical care, that a questionnaire be sent to both the American Federation of Labor and CIO local secretaries of each major community of the state, and to the members of the Connecticut State Medical Society, the questionnaire to be as follows. I put this in the agenda so that it would acquaint the members of the House of Delegates with a plan that might be very beneficial to the committee and to the members. We are not asking that it be voted on at this time because it hasn't been voted on in our own committee.

President Miller: That perhaps was a misunderstanding on my part.

Dr. Soltz: It was agreed to defer action on the questionnaire until after the meeting with the insurance carriers, which we expect to have some time next month.

President Miller: Then there is no action required of the House, and would you move the adoption of the report?

Dr. Soltz: I would appreciate it if the members would read the recommendations and the questionnaire, and if anyone wants to comment on it, I would appreciate it. They can even write me a letter, if they want to, and give me their opinion. I would appreciate it very much.

The report of the Committee to study the Workmen's Compensation Laws was then adopted as presented.

President Miller: The report of the Committee on Prepaid Medicine will be placed before you. I will ask Dr Harvey to come forward to take the chair.

Dr. Harvey assumed the chair.

Dr. Miller: Mr. President, the Committee on Prepaid Medical Service places before you the report, and to get it before the House, I move its adoption.

Dr. Gibson: Second.

Chairman Harvey: The report of this committee is moved and seconded. Is there discussion?

Dr. Miller: May I, as chairman, discuss it at this point? I think all members of this house are familiar with the fact that we have gone up and down the state, members of the county associations have discussed this report, and this general subject in various meetings. It has at no time been the purpose of the committee to evolve a plan and wish it on the Society. The history of this committee is long and varied. It has at one time presented to the House of Delegates one type of program, to have it turned down, and presented another at another time, and so forth.

It is important for us to have in mind the history of the actions of this House, in order that we do not go astray in our thinking. The committee has no purpose other than to lay before you plans which might be adopted. We have no feeling that the plan presented originally is the ideal one. In fact, as we have gone about the county societies, we have obtained certain impressions which I think would be quite improper for me, as chairman of the committee, to codify. I therefore will terminate my discussion, and be open for questions if I can be of service. I think it is a matter for the delegates to determine themselves.

Dr. Buckhout: Mr. Chairman, we are not now voting on the conclusions offered by the committee, are we? We are voting on the adoption of this report? Am I right?

Chairman Harvey: That would be my ruling, I think, to adopt the report, and then I presume the House will proceed as indicated in the report, to specifically approve of one of the three choices that occur in the report. Is that in agreement as to the intent of the committee, Dr. Miller?

Dr. Miller: It would be my thought that you can clear the decks in any fashion you wish. You can turn down the report and start anew. Then you don't have to amend anything and get into a morass of parliamentary tangle. That, perhaps, might be the cleanest way to do it. And believe me, the committee has no tender feelings on this subject, merely an attempt to get it before you. It would be my thought that you turn down this report, and then start there and go to work and do anything you wish.

The report of the Committe on Prepaid Medicine was then accepted.

Chairman Harvey: That would be my interpretation.

Dr. Burlingame: Question.

Chairman Harvey: Those in favor say aye. Opposed? The ayes have it and the motion is carried.

Now, I think it is in order to move for one of these three proposals, which I think it would be well to read.

Dr. Shepard: I move the acceptance of paragraph A, in preference to B or C, at the conclusion of the report.

The motion was seconded.

Chairman Harvey: It is moved that paragraph A be pproved, rather than B or C, and the question is now open r discussion.

Dr. Buckhout: Mr. Chairman, I speak for Fairfield ounty when I make this point. Fairfield County, I might y, in introducing this, accepted plan A, with certain servations, and may I, at this time, present those reservaons in the form of amendments? Is that in order now?

Chairman Harvey: Yes, I think that is in order.

Dr. Buckhout: We therefore aceept plan A, as given in ie conclusions of this modified report of the eommittee; owever, we wish to delete the portion which says, "To ncourage the sale of such contraets approved by the ociety by eommercial insurance earriers and non-profit aring corporations." The portion of that sentenee we ould wish to delete is "Commercial insurance carriers." n other words, Fairfield County wishes to have this carried y a non-profit organization entirely. We also wish to ecommend that the management of this non-profit organiation be under the constant eye of the state organization. nd I so wish to amend this paragraph A.

Chairman Harvey: You have heard those two statements. Will you aeeept the amendment?

Dr. Shepard: Yes, I will.

Chairman Harvey: Will you discuss the motion and the mendment?

Dr. Danaher: It has been my opportunity to be in the st House of Delegates when this was discussed, the first eport of the Committee on Prepaid Medieal Service. It vas rather an interesting discussion, as those of you who vere there know. We went through a special meeting on in Hartford, and we had another meeting in New Haven, vhere I happened to be a representative from our hospital. am very sure that it was educational for me, and I think o everyone here. The conclusion that I came to was that ve could not get any one plan, the details of which would e acceptable to 100 per eent of this organization. But I ee no reason why we can't get a plan that is acceptable o the majority of the group. As I think of the number f hours that were spent by many of us trying to get a vorking knowledge of prepaid medical care problems, and nake some feeble attempts to amend those plans, I realize vhat a tremendous job must have been done by the comnittee of Dr. Miller. I believe that we are all indebted to hat eommittee for foeusing our attention on this problem.

I am rather afraid that the members of that committee, n account of the criticism that they have received, because ve didn't agree with all their conclusions, rather feel that ve do not appreciate their work. I, for one, do appreeiate he work that they have done. In the beginning, we were good deal like the 14 year old who didn't think his ather knew very much, but by the time he got to be 21, ie wondered how the old man learned so much in a few years. This eommittee, I feel, has done a pretty grand job f bringing our attention to this problem. I further think hat this is a very important problem that has come before his House of Delegates. In fact, to my knowledge, it is nost important.

I wonder if we all realize how important it is in our public relations that we soon get a prepaid medical plan that is workable. As far as the details, I believe we have got to leave those to some eommittee. I am in favor of the amendment and the motion, as read.

Chairman Harvey: Any further discussion?

Dr. Root: Mr. President, the delegates from New Haven County were instructed to vote for a medical plan similar to the plan in Massachusetts. Several years ago, I think that many people remember and some people seem to have forgotten, the House of Delegates did approve of a plan to be organized along with the Blue Cross. Certain monies were appropriated from both the Blue Cross and the State Medieal Society. A Board of Directors was organized, and so forth. Then the Blue Cross welehed on the plan and left it up in the air. Now that plan was approved by the House of Delegates. I wonder, in reading Dr. Landry's report, he says that the Blue Cross is beginning to feel that competition, one paekage insurance, medieal care, and so forth, is going to do them a lot of harm. I wonder if the Blue Cross has changed its mind. I wonder if anybody has explored that recently. I think the delegates from New Haven County would like to explore that further.

Chairman Harvey: Dr. Miller, ean you answer the question of Dr. Root?

Dr. Miller: I don't know, in the time that we have before us, with the low blood sugar that we have this morning, whether it is possible to go into that too far. I think the serviee type of contraet certainly is going all over the country. The Blue Shield, let us call it that, is developing in many states. As we have gone about this State, there seems to be general favor of that type of plan. Just what the levels should be, just what the allowances should be is, after all, a matter of adjustment. No one can sit down in the privacy of his own office and figure out satisfactorily for a lot of other men in different parts of the state. Our relationships with the Blue Cross here have not been too different from those which have taken place in other states where groups of men are impelled by a basic desire to do something for the public, espouse a certain pattern of doing it.

They find some difficulties in adjusting their patterns with other groups. I mean specifically the Blue Cross for hospitalization care and the Blue Shield for medical care. I think, if this house, in its wisdom, comes out of this meeting with a Blue Shield type of eontraet care in view, we still have not solved the whole question. It is essential that any service type of contract be under the control of the medical profession. I am not quite certain whether the Blue Cross gentlemen are willing to take that. That has to be negotiated. When you are asking businessmen to do the business work for you, they sometimes will say, "Well, if we are going to do the business work we will control the situation."

As long as we are going to underwrite—if we decide to do so—a service type of contract, we, the profession, must control that. Inherent in every service contract is the necessity to exercise diseiplinary control over our service, which is over our own members, and we will not submit to discipline from outside people. We must do it ourselves. Whether we have been up to that in the past, whether we have done our full duty in that, is beside the point. It is

inherent in every service contract that we must have executive control over the essentials of that contract, and we must have disciplinary power over our own members. Now, whatever you decide can't be wrapped up and sold on Chapel Street tomorrow. It may take a year to negotiate this. These people have got to sit down together and agree to give here and give there; and your representatives, whoever they are, have got to be able to negotiate, bearing in mind the fundamental things, that we must control service, if we are going to make it work.

CHAIRMAN HARVEY: I would like to raise a question, at the suggestion of the Secretary. It is obvious that this discussion may well go on for some time. The luncheon is already served. And if I don't hear disapproval, why, I would suggest that we go to luncheon and reassemble at 2:15 P. M.

The morning session was recessed at 12:50 P. M.

Chairman Harvey called the afternoon session to order at 2:20 P. M.

CHAIRMAN HARVEY: The House will come to order. The Secretary will call the roll.

Secretary Barker called the roll.

CHAIRMAN HARVEY: The motion is before you, and we will proceed from where we adjourned for lunch. The motion was one approving plan A, as given in the report of the committee, leaving out the provision for carrying it by commercial insurance carriers, and adding, under the constant surveillance of the Society. I will recognize Dr. Watson, who asked for the floor when we adjourned.

DR. WATSON: I am going to report for the Hartford County Association, where this proposition was discussed at great length. It was also brought up at this meeting, the fact that there were some factors about commercial carriers that some of the men did not like. However, it was unanimously voted at our meeting to accept proposition A, as it was recommended by the committee. I would just like to report that. Without representing Hartford County, I am wondering if it would not be feasible, with all deference to the doctor from New Haven County, to pass on this proposition, leaving out the entire line or the entire sentence, to see if we can't give our committee the support they need first. And then perhaps to go into the details as to whether the group favors commercial carriers or not.

It seems to me that decision, rather than put all our eggs in one basket and be subject to the demands of one particular group, should be left to the committee, and competition is always better.

DR. BISHOP: Mr. President, I should like to report to the House of Delegates the attitude of the New Haven County Association, as it was expressed at its annual meeting on Thursday last. I am one of the delegates. I am not normally its spokesman, but I feel that the matter should be presented to you in the terms that the Association considered. After a lengthy and extended discussion of the problem, the New Haven County Association voted to instruct its delegates to endorse a plan for prepaid medical care similar to the Massachusetts plan. Briefly, the critical considerations of the Massachusetts plan which were presented to the New Haven County Association, and of which it approved, are these—and I would ask the Secretary that if I should make an error in my statement about the Massachusetts plan, t correct me—firstly, that it is a non-profit organizatio secondly, that the prepaid medical service is a contra provided for persons below a fixed level of income, th level being $2,000 for single persons and $3,000 for familie No differentitation is made between man and wife, and ma wife, and children, in the sense of families.

Thirdly, that beyond the limits, below that income lev for which the service contract operates, the plan functio as an indemnity plan, providing payments for that portio of the physician's bill which coincides with the servic charges permitted under the insurance plan, and such di ference as may exist between them, between that reimburs ment and the total bill, is a matter of personal arrangeme between the physician and the patient; that the non-prof organization be controlled by a directorate, of which a least fifty per cent of the members of the board are phys cians; and fourthly, that so far as the possibility exists fo cooperation in terms of administrative detail and selling pu poses, that a close degree of cooperation exist between th plan and the Connecticut Hospital plan, although the tw plans are corporately distinct.

As I said, the vote of the Association was to instruct it delegates to endorse a plan similar to the Massachuset plan. Mr. President, if an amendment is in order, I shoul like to introduce the amendment, that the proposition b accepted, in the details as published, with the further con sideration that it be considered in the sense of the Massa chusetts plan, with the features that have been elaborated.

DR. SHURE: I second that amendment, Mr. Chairman.

DR. WATSON: Is that an amendment to the amendment

DR. SHURE: It is an amendment to the motion.

DR. STRINGFIELD: May I ask a question? How does thi proposal differ from the proposals in the New York plan I would like to ask Dr. Miller that question.

DR. MILLER: First of all, I think Dr. Bishop was incorrec in the top limit in Massachusetts. The top limit is $2,50 for families, not $3,000. The New York plan differs only slightly in some of the allowances, and in the income levels The income levels in the United Medical Service Plan ar $1,800 for the individual and $2,500 for the family, an there is an area from $2,500 to $3,500 in which the fee, i objected to, is subjected to a reviewing committee of th Society, whose decision is final. That arbitration mechan ism is not in the Massachusetts plan. I think that is th main thing. The other is that the United Medical Servic Plan has a subdivision of the various types which can b bought by the indvidual, or for him by the group, his em ployer. There is a medical type, a surgical, and a combina tion of both; I think those are the essential features in which they differ.

SECRETARY BARKER: Mr. Chairman, Dr. Bishop gave me the privilege of correcting what he had to say, and I am not up here to correct what he had to say, but to supplement it. I think there is an important thing in the Massachusetts plan which may not have come back to your mind at this moment. It is an unusual provision in plans of this kind. The Massachusetts plan does not pay anything to non-participating physicians. That is a provision, as far as I know, that is not in any of the other plans. It is a very drastic

rovision. Ordinarily, a non-participating physician will be aid like an out-of-state physician, the cash allowance. But Massachusetts, they do not pay, except for limited serv- e in a frank emergency. And if you are going to adopt recommend the adoption of the Massachusetts plan in to, bear that in mind, because that is worthy of a good eal of consideration before you adopt it.

Dr. Miller: Mr. Chairman, may I just add something to at? I neglected to bring in that point. Dr. Fred Elliott, hen he was here, laid stress on that. He said they had arted out that way, recognizing bills only from their embers, and had rapidly given it up, and they were oadminded there, and they paid anybody for services ndered. And the allowances were paid without prejudice not being a member.

Chairman Harvey: The second amendment is in order, it if the chair may take the freedom, I would like to ggest that we keep this as broad and as clean-cut as pos- ble. If each person who arises tries to put another amend- ent on it, we will simply get confused. It is a general inciple that is involved, not details. Those will have to worked out separately. I have the feeling myself that r. Bishop has expressed already the feeling of the New aven group and if, however, you wish to proceed with discussion of the amendment, that is in order.

Dr. Soltz: Mr. President, for a small county, New Lon- on, we were very much honored by a visit a couple of eeks ago from Dr. Elliott and Mr. McCormick who, I ink, is vice-president of the United Medical Service Plan. We had a long discussion. We had the whole evening to urselves, and probably two hours was consumed in their lk and questioning. We were very much impressed by ie United Service Plan of New York. There was one thing at both of the speakers stressed, that the hospital plan and ie medical plan should be kept separate. We were in- ructed in New London County to come here and favor plan that approximates the New York plan. Our delegate New Haven County, Dr. Hartman, listened to the talk y Dr. Elliott and Mr. McCormick, and he heard the lassachusetts plan and he was equally impressed with the lassachusetts plan. So New London County is instructed support a plan that simulates the New York plan.

Chairman Harvey: We are discussing Dr. Bishop's mendment now.

Dr. Fisher: I just wish to say that Middlesex County in- ructed its delegates to favor plan A, without amendments, nd leaving the details to the committee to work out, trust- ng in their integrity.

Dr. Shure: In regard to the discussion, Mr. Chairman, eld at New Haven, I think, after a dragged-out affair, vith all Queensbury Rules barred, we came to some con- lusion, something that we had not done before, primarily: 1) That some service plan should be incorporated; (2) hat some policy should be adopted. And from our meet- ng, the delegates were given to understand and instructed hat a policy should be adopted similar to the Massachu- etts plan. Now, that, in no way, forces us to accept the Massachusetts plan, nor does it exclude the New York plan. It merely gives us a go-ahead signal to make some policy that resembles something that we ought to have. t takes us out of a state of chaos that we have been in up until the present time.

I think there has been a misunderstanding, because Dr. Miller came from Hartford, and the insurance company basically do business in Hartford, that we were going to have a policy that dealt with only insurance companies.

Now, that wasn't the committee's idea, and that wasn't Dr. Miller's idea, I have been given to understand. The idea was to get a policy that was fair for the public and fair for the doctors. Now, I have been an antagonist to his policy before, because I think there has been a misunderstanding, and I think now we all understand the problem. Something must be done, and we now approach it from two sides. Fairfield and New London County say that we should have a prepaid medical policy, and they prefer New York, the United Medical Service, I think it is called. New Haven County, by virtue of the splendid talk we had from Massachusetts, prefer the Massachusetts plan. We are not instructed that we want the Massachusetts plan, or we are to have that. We are instructed to have a policy similar to it. And it is possible, between the New York plan and the Massachusetts plan, Dr. Miller's committee now knows what we should have, and I think the problem now is at a head.

Dr. Burlingame: Mr. President, Hartford County and some other counties have voted on these three projects as is. Now, we are instructed in Hartford, to endorse plan A, leaving it very much as Dr. Fisher has said. It seems to me that we are entitled to vote on that, and if that is defeated, then take up amendments; in order that that may come about, I therefore offer an amendment.

After considerable discussion this amendment was defeated.

Dr. Shure: Mr. Chairman, I would like to make a motion that we have a policy adopting the service portion of this report, and that a policy embracing the Massachusetts and the United Medical Plan be adopted. Do I make myself understood?

Voices: No.

Dr. Shure: Well, I will. New Haven County voted on the Massachusetts plan only because it was presented to us in detail. We understood it. Fairfield County and New London County understood the New York Plan, or the United Medical Plan. They have a right to their opinion. Apparently, and from what I gather from talking to Dr. Miller, there is very little difference between the two plans. If we accept this compromise, that a plan be adopted resembling both the Massachusetts and New York plans, you have something to work with, and you do not throw the whole thing out of the window and make your committee work endlessly for nothing. There you have something, and I offer it as such, that we adopt a plan resembling the New York and Massachusetts policies. I make that in the form of a motion.

Dr. Root: I second the motion.

Dr. Thoms: I wonder if Dr. Shure would accept an amendment that the committee, in presenting plans, be guided by the New York and the Massachusetts plans?

Chairman Harvey: Do I understand, Dr. Shure, that your motion is other than that, in agreement with plan A?

Dr. Shure: May I ask a question before I answer that?

I am sure the committee will take into consideration both the good points of the Massachusetts plan and the New York plan, so I accept the amendment of Dr. Thoms.

The motion was seconded.

Chairman Harvey: Do I understand your original motion barred the commercial insurance carriers?

Dr. Shure: In essence, yes. It does in this respect, because both the other policies are non-commercial, and you are accepting their plan in principle, not definitely the Massachusetts plan or the New York plan. You see, we are guided by certain precepts, and if I may take just two minutes, it will probably answer some of the questions they asked of Dr. Miller.

It is a question of who will run it, who will be in charge of it, what fee will be charged, and how the policy will be conducted. Now, the Massachusetts plan, which I am better acquainted with than the New York plan, takes that into detail. And it did seem to the New Haven County Medical Association as the fairest policy, both to the public and to the doctors. I cannot speak for the New York plan. But having been given the information that it resembles the Massachusetts plan, I thought a combination of both would lead us to a solution, with the best possible policy for the public to which we are responsible and for ourselves in which we are deeply interested.

Dr. Thoms: Mr. President, I might point out with regard to the Massachusetts plan, the majority of the directors on the Massachusetts plan, I don't believe, are physicians. They have a physicians' committee that has charge of the medical service feature of the plan, and they really have charge of the servicing of the plan. Am I right, Dr. Miller, in saying that the majority of their directors are not physicians?

Dr. Miller: They do not have to be physicians, but they have to be selected by the State Society. That is the control. In the New York plan, the majority have to be physicians, licensed to practice in New York State, and their nominations have to be acceptable to the Council of the State Medical Society of New York.

Dr. Thoms: That is why I wish to use the words, that the committee be guided by these plans, and not attempt to try to adopt both of them at once.

Dr. Shure: I move that the House of Delegates approve a prepaid medical plan. Part No. 1 is, including service and indemnity features. Part No. 2, is with an income level for the service feature and a maximum income level, blank. I am leaving the amount out, for the committee to decide. This plan shall be written by a non-profit organization. A majority of the directors of the non-profit organization must be physicians.

Now, that may raise a question. Your committee can bring that back if that is too tough. The prepaid medical service committee is authorized to proceed at once with the development of the program. I have mentioned nothing about states.

This motion was carried.

Dr. Miller: Mr. President and Gentlemen: The battle is not over, it has just begun. I don't mean the battle here. Your committee has a deep sense of satisfaction in the action of the House of Delegates in approving the service plan of prepaid medical service, to be provided by a non-prof organization, controlled by the medical profession. It the type of operation successfully adopted in many state and was the original proposal made by your committe several years ago. (Laughter.)

Your committee is also pleased to note the increase interest in and knowledge of prepayment plans on the pa of the members of the Society, as evidenced by the di cussions at the largely attended meetings of the Count Associations during the past year. The society's prese committee has made the necessary technical and analytic studies, and endeavored to inform the membership objec tively, so that it could make its decision. That decision h been made today, and the way is now open for the develo ment of a non-profit service and indemnity plan, as a proved by the House, and a committee representative all areas and interests in the state will be required.

Therefore, the committee recommends to the House Delegates—and I wish you would pay close attention t these recommendations, because we mean them with gre earnestness—

(1) That the present committee on Prepaid Medical Serv ice be discharged.

(2) That each county association be requested to nam one member of a new state committee on Prepaid Medic Service, and inform the Secretary of the State Society the appointment before June 1 of this year. These appoint ments can be made by the county associations in any wa they wish, by the president or governing board of th association, or by election at a special meeting of th association.

(3) That as soon as practical, after June 1, the Presiden of the State Society shall call the appointed members o the committee together in its first business meeting for th purpose of electing a chairman and secretary of the com mittee, and discussion of the committee's objectives. There after, the committee shall operate on its own initiative, an seek such counsel and advice from within and without th state as it deems advisable.

(4) That the committee may request the council to cal a special meeting of the House of Delegates at any tim when the committee has a plan and method of operatio prepared for consideration by the delegates.

(5) That the council be authorized to make available from the funds of the Society a reasonable sum of money for the ordinary operating expenses of the committee.

(6) That when a plan has been devised, approved by the House of Delegates, and placed in operation, this com mittee shall continue as the Society's representatives in it operation, and vacancies on the committee shall be fille by appointment by the county association in which th vacancy has occurred; and the President of the State Society shall at all times be a member of the committee, wit privileges equal to all other members of the committee except he shall not serve as its chairman.

If I may comment on that suggestion by the committee it is made in all seriousness, without pique, without any idea of being disappointed that you didn't take our advice right off. Had you done so, I think we never would have been able to sell the plan when we met you in the staf

room, hospital by hospital. A plan, to be successful, must be a part of the thinking and sense of obligation of every member. And in order to get that done, it is essential that the controlling committee may stem from the county societies. As I said earlier this morning, there is inherent in any such enterprise the matter of discipline of the unfortunate members of the society who do not measure up to our customary standards. It is highly important, that the sense of authority stem from the county societies; if discipline is necessary, it must stem locally.

You must use your own boards of censors, or some other mechanism. Members of a county society will not take kindly to discipline which is meted out from state headquarters, or a committee which is appointed from above. It must come from below. So I therefore present the considered judgment of our committee in that report, and would move its adoption.

The motion was seconded.

Chairman Harvey: The motion is made and seconded. Will you discuss it?

Dr. Shure: I would like to make an amendment to that motion. I would like to make an amendment that the present committee, before they are discharged, act in a consultative capacity to the new committee.

Dr. Miller: Mr. President, the members of this committee, like the poor, will always be with you, and are always at your service. I don't believe you need to pin any obligations on us.

Dr. Foster: Mr. President, I would like to make an amendment that the members of this committee be thanked by the Society for the work they have put into this plan.

The amendment was seconded.

Chairman Harvey: Do you mind if we put the original motion, and then you can put your motion as a separate one, which makes it even more distinguished? Are you ready for the question on the original motion? All those in favor say aye. Opposed? It is carried.

Now, I will submit what was an amendment, and has now become a motion. Any discussion? Those in favor say aye. Opposed? It is carried. (Applause.)

Dr. Miller resumed the chair.

President Miller: This morning when we opened, we had a quorum, which is considerably smaller than the present attendance. My thought at that time was to express my gratitude to you for the opportunity to serve you. Service has its own reward, and we don't have to be given votes of thanks. It carries its own reward. Thank you very much. (Applause.)

Dr. Bishop's report on the Reorganization and Objectives of the Society is before you. Will you present those recommendations, Dr. Bishop?

Dr. Bishop: Mr. President and Members of the House of Delegates: I will, for the sake of brevity, and in an attempt to expedite this matter, present to you each successive recommendation, as it was embodied in the substance of the report. The first recommendation concerns the physical requirements of the state office, that the council take such steps as, in its opinion, are necessary and desirable to alleviate promptly this shortage of space.

This recommendation was adopted.

Dr. Bishop: That the council provide, at its discretion, and subject to its resources, sufficient secretarial assistance. That refers again to the state office.

Recommendation adopted.

Dr. Bishop: Thirdly, as concerns a retirement plan for permanent employees of the state office, it is in three parts, Mr. President. Do you wish each part presented separately?

President Miller: You might read it all, and then if it seems necessary to anyone to consider them separately, we can do so.

Dr. Bishop: The recommendations are: (1) That a retirement plan be adopted; (2) that the Society shall bear 50 per cent of the cost of the annual premium, or that portion of the annual premium that does not exceed 10 per cent of the employee's annual salary; and (3) that the council appoint a committee, exclusive of employees of the society, to investigate in detail such plans, and present its final recommendations to the council for execution.

These three recommendations were then adopted.

Dr. Bishop: That the council be authorized to investigate and maintain such insurance coverage, compensation and public liability, and that the status of insurance coverage in these categories be reviewed annually.

Dr. Burlingame: I so move.

The motion was seconded.

Dr. Bishop: Dr. Barker asked me to remind you that in the substance of the report, it was pointed out that insurance coverage in both these categories has already been established at the suggestion of the executive secretary. It was the opinion of the committee that such coverage should be maintained in the future.

President Miller: The motion has been made and seconded. Do you wish to discuss? If not, those in favor say aye. Contrary? Carried.

Dr. Bishop: In order to establish the status of exemption from unemployment compensation tax as a matter of record, that the council direct a specific written request for an official opinion to the Unemployment Compensation Department at Hartford.

Recommendation adopted.

Dr. Bishop: That the council be authorized to purchase, for ownership and maintenance by the Society, a suitable automobile for the use of the executive officers of the Society, in the conduct of its official business.

Recommendation adopted.

Dr. Bishop: That the council prepare and present to the next meeting of the House of Delegates such amendments to the present by-laws as are necessary, so as to provide for suitable and orderly succession of elected officers of the Society, in the event of death or incapacity.

Recommendation adopted.

Dr. Bishop: That the President appoint a special committee to confer with presidents of the component county associations, with the hope that they may study and develop procedures which will obviate these discrepancies, as pertains to the uniformity of county association by-laws.

Recommendation adopted.

Dr. Bishop: That the president appoint a committee consisting of the Executive Secretary of the Society, or his representative, and the Secretaries of each component county association, to study and effect such of these suggestions as prove practical. That relates to the matters of inter-office business procedures.

Recommendation adopted.

Dr. Bishop: That the public relations section be continued, and that special attention be directed to its expansion.

Recommendation adopted.

Dr. Bishop: In respect to the financial structure of the Society, the committee recommends: (1) That the council be authorized to institute such changes of equipment, procedure, and personnel as are required to operate and maintain modern accounting methods, as are recommended by suitable agencies, and approved by the council; (2) that the present revolving fund of the Hartford office of the Journal, and the payment of current accounts in that office, be eliminated by relocation of the account in the office of the State Society, that collections formerly made by the Hartford office be made through the central office of the Society, and that accounts payable by the Hartford office be handled by the forwarding of approved vouchers to the central office of the Society for processing; (3) that the basic determination of annual dues must depend on a strict annual budget, which shall consider in detail the cost and extent of the Society's anticipated program, and the alignment of income to expense.

Dr. Gold: I move its adoption.

The motion was seconded.

President Miller: Motion is made and seconded to adopt that recommendation. Will you discuss it?

Secretary Barker: Mr. Chairman, may I speak to this? Dr. Weld, would you care to speak about it first? I would be glad to have you do it, if you like.

Dr. Weld: You first, please.

Secretary Barker: My understanding is that this is a tentative recommendation, and if that is the thing that we are supposed to do in our office, we will do it. However, I am afraid that you are, in good will and confidence, facing us with something that may be, in part, at least, impossible, or at least inadvisable. And that is, that our office be charged, the treasurer's office be charged with the collection of money due the Journal, the collection of it. That would mean a good deal of confusion and complication between Dr. Weld's office and mine, and I don't think it would really serve a much better purpose.

Dr. Weld solicits the advertising, makes the advertising contracts, fixes the cost of advertising. He handles the entire advertising account of the Journal. I do not think that it would be advisable to take that responsibility or privilege from the Journal office.

I am afraid we would always be in a rather confused state, no matter how much we might try to do it correctly. I would like to have you consider here, and I would like first to have Dr. Weld get an opportunity to discuss it, perhaps the elimination of that middle phrase, which starts in the fourth line, therein the recommendations, and runs through the first word on the third line from the bottom. May I ask Dr. Weld a question, Dr. Miller?

President Miller: Please.

Secretary Barker: Are you in agreement with me or that idea, Stan?

Dr. Weld: Yes. Strange as it may seem, we arrived almost at an impasse with the Post Office Department lately and I am afraid this is just going to add to that. We have had mail lost, we have been days and days getting mail from New Haven to Hartford, and vice-versa, and I don't know the solution. I think this will just add to our headaches. If this is a plan that should be adopted, I think it should be postponed until the Society, including the Journal, is under one roof. Then it may work out efficiently and satisfactorily.

But at the present time, I agree entirely with Dr. Barker. I think it would add too much to his difficulties, and not simplify our office a bit.

President Miller: You have the suggestion of deleting certain words there in the recommendation.

Dr. Thoms: May I ask Dr. Weld if the rest of the phraseology is acceptable?

Dr. Weld: I think that is a policy which the accountants have considered advisable. I see no objection to carrying out this suggestion, which I think came from the accountants. It would simplify their bookkeeping.

Dr. Bishop: I will re-read the suggested correction: The present revolving fund of the Hartford office of the Journal, and the payment of current accounts in that office, be eliminated by relocation of the account in the office of the State Society, and that accounts payable by the Hartford office be handled by the forwarding of approved vouchers to the central office of the Society for processing.

This recommendation was adopted.

President Miller: Is there any old business before the House? If not, have you any new business to bring up?

Dr. Dewey Katz: Mr. President, I want to present a resolution: Resolved that the Connecticut State Medical Society recognize the twenty-five years of useful service in the field of health education which has been performed by the magazine *Hygeia*, the lay health publication of the American Medical Association, and hereby urges members of the Society to cooperate in extending the usefulness of this publication in every way possible, in particular by encouraging the efforts of the Woman's Auxiliary to the Connecticut State Medical Society in promoting this magazine.

Resolution adopted.

President Miller: Is there any other new business to come before the House?

Secretary Barker: I think it is known to the gentlemen of the House that Dr. Osborn, the Health Commissioner, has been rather gravely ill following an operation on a ruptured appendix, and he sent me this note, without the suggestion that it be read here, but I would like to read part of it to you, the fourth and fifth lines: "I am disappointed not to be able to be on the prowl in Fairfield next week. Please remember me to all the fellows and wish them good luck. Stanley Osborn." I would like to move, Mr.

hairman, if I may have the privilege, that we extend our est wishes to the commissioner, while he is ill.

Motion carried.

President Miller: Is there any more business to come efore the House?

Dr. Shepard: Mr. Chairman, I would like to bring to the ttention of the House of Delegates an unfortunate thing, hich I think we ought to know about. Some year or so go a questionnaire was sent to the doctors of the State n regard to the practice of pediatrics. We received a ecommendation from the State Office that those questionaires be filled out carefully, as requested. Apparently, some f the data collected in that questionnaire is at present being sed in a way that astonished me, because of apparent disortion of the fact. And since the State Society has recomended to the doctors that they fill it out, I think it bears me responsibility for the use to which that questionnaire put.

President Miller: Dr. Root, would you like to discuss it?

Dr. Root: Well, this comes as a great surprise to me. ome of the social agencies of the State have asked for me of the limited information which we have. I might dd that the Academy of Pediatrics, the State branch, is ow in the process of writing a final report, and that othing has been made available to the public, except cerin facts, which I don't think anyone will take exception o, and nothing will be made available until the final report completed, and until we have the statistical data from Washington, which we will not have before July 1. At hat time, either the full report or a summary of it will e published in the Journal.

Dr. Shepard: I substantiate my fears by the statement hat was made to a group of women, the Women's Auxiliry of the Society, that Windham County was cared for n a pediatric way by a single doctor, and he was a general ractitioner who devoted only parttime to pediatrics. When he question was raised as to whether he covered pediatric are in both hospitals in the county, that was affirmed. That doesn't make very good sense, and it shouldn't have een derived from the questionnaires that we filled out.

President Miller: Any other remarks? May I call your ttention to the meeting tomorrow, and the dinner tomorow evening. Dr. Bortz will be there. We shall have the rivilege of listening to the Governor, and I think it is ery important for us to know our Governor, because we vork with him in many ways, we are in many ways enmeshed into the wheels of progress as it is officially adminstered on the top level by His Excellency, Governor Shannon. Dr. Howard wants to make an announcement.

Dr. Howard: I just want to make an announcement that he council dinner will be held this evening in the next oom; and tomorrow night the banquet will be held upstairs. Most of you have been rather slow in sending in or your tickets, so the reservations have not been very ast in reaching us. We have to let the hotel know very hortly how many will be there. So if you have not sent n your reservation, will you please do so on your way ut, and get your tickets.

President Miller: If there is nothing more, I will declare he meeting adjourned sine die, and thank you very much for your close attention. (Applause.)

The Annual Meeting of the House of Delegates of the Connecticut State Medical Society was adjourned at 3:45 p. m.

CORRESPONDENCE

Veterans Administration

Washington 25, D. C.

To the Editor:

It would be deeply appreciated if you would print the following notice in your publication.

"The Veterans Administration has in its custody the majority of syphilis records of those Army personnel who were treated for this disease while in active service, and in many instances can procure informative data from the syphilis records of other than Army personnel. It is thought that many physicians treating veterans for syphilis as private patients would find a resumé of the syphilis record useful since the details of treatment, results of spinal fluid examinations, and blood serologies are incorporated in the records.

"Resumés of these records are available to physicians who are treating such veterans provided authorization for the release of the data is given by the veteran. Requests for the resumés accompanied by an authorization for the release of the data, dated and signed by the veteran, should be addressed to the Dermatology and Syphilology Section, Veterans Administration, Munitions Building, Washington 25, D. C. It is most important that the veteran's Service Serial Number and other identifying information, such as the date of enlistment, the date of discharge, rank, and organization be included.

"Ordinarily the resumés can be furnished in approximately two weeks from the date of the receipt of the request and signed authorization."

Paul B. Magnuson,
Chief Medical Director

Vagitus Uterinus

To the Editor:

The following instance of vagitus uterinus may be of interest to your readers and I am therefore taking this opportunity to briefly outline a case which was under my care recently.

The patient was a 24 year old primigravida at term and in labor. She had a twin pregnancy. The leading fetus presented as an occiput posterior.

When dilatation was about 5 cm. the membranes were ruptured. At 8 cm. dilitation low spinal (saddle block) anesthesia was given. One half hour after the block, the cervical dilatation was complete and the patient was moved to the delivery room and prepared for delivery.

Vaginal examination revealed a compound presentation. A hand was presenting with the occiput. On determining this complication the examining hand was withdrawn and the findings were explained to the nurses who were present. As we were discussing the presentation we heard a cry. Then we heard another cry, and the patient exclaimed, "That must be my baby!" A third crying episode then occurred, and this we recognized as arising from within the mother.

Delivery was then effected. The leading twin (th one which cried) needed some aspiration but r resuscitation. The second twin, the membranes (which were intact, needed active resuscitati measures after delivery. These were dizygotic twin

The reports of vagitus uterinus show it to be rare occurence, up until January 1947, only 1 cases being authentically reported. For its produc tion the following conditions are necessary: ruptu of the membranes, entrance of air into the birt canal, and stimulation of the fetal respiratory cer ter. This case fulfilled these requirements. Th entrance of air into the uterine cavity was apparen ly facilitated by the compound presentation an the fetal respiration was stimulated by vagin examination.

Max L. Berlowe, M.D., New Haven

WOMAN'S AUXILIARY

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President, Mrs. Charles W. Goff, West Hartford
President-elect, Mrs. Ralph L. Gilman, Storrs
First Vice-President, Mrs. F. Erwin Tracy, Middletown
Second Vice-President, Mrs. Charles H. Sprague, Bridgepo
Recording Secretary, Mrs. Paul Vestal, Woodbridge
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NATIONAL LEGISLATION AND THE INDIVIDUAL

Joseph S. Lawrence, M.D., *Washington, D. C.*

The Author. *Director of the Washington Office, Council on Medical Service, American Medical Association*

The National Health Assembly, which convenes in Washington this week, has a most excellent opportunity to bring to the American public a knowledge of the marvelous achievements made in the health field since the Conference of 1938. But will it rise to the occasion? Will it recognize the great progress attained in the reduction of pneumonia, tuberculosis, and typhoid fever? Will it herald the advancements in medical service that have resulted in the marvelous prolongation of life? A hundred years ago the average person died a forty. In 1900 the average term of life was onl 47 years. However, by 1940 it had increased to 6 years, and the latest census report shows that a chil born today may live a possible 68 years.

Will it frankly admit the safety which attend maternity in this country? An editorial writer i the New York *Times* last Monday morning ha this to say:

"The statistics of good maternity hospital service in New York, where the maternal death rates ar less than one for each 1,000 live babies born, shoul serve to emphasize the pride which New Yorker take in the record of the Maternity Center Associa

Statement from an address delivered before the Woman's Auxiliary on April 28, 1948

on . . . Of the mothers cared for by the sociation's nurse-midwifery service not one has ed in the past ten years.

"The agency's thirtieth annual report makes it ear that in no country of the world is it safer to ve a baby than in the United States."

Will this Assembly give credit to the research orkers who have given us the new drugs and our wer knowledge of the properties of blood and its nstituents? Will it accept the conclusions reached the Brookings Institution in the report it recently blished on a study made of the "Medical Care For e Individual?" In part it reads:

(1) Probably no great nation in the world has nong its white population better health than preils in the United States.

(2) It is apparent that the United States under its oluntary system of medical care has made greater ogress in the application of medical and sanitary ience than any other country. This progress is w reflected in low mortality and morbidity rates infectious diseases and in increased life expectncy. There is every reason to believe that these ends will continue unabated under our present stem of medical care.

Or will it report the unsupported interpretations f the Selective Service findings in the health examation of our youth; and, by the way, the latest port from Selective Service, by concentrating pon the acceptance for Army service rather than e rejections, has refuted many of the early charges ith regard to the physical condition of our youth.

Will it continue the insinuations that the health f our children is being neglected, that there is a ortage of physicians, and that medical service is adequate? Will it accuse the public of not having health department operating in one-third of the ounties of the United States without stating that n none of those counties does the population exceed 5,000 and in some of the very latest of these counes the population is less than 5,000, areas in which would be physically and economically impossible establish health units.

In spite of all these achievements, will it endeavor continue the delusion that the Federal Governent can furnish better medical service than that hich is now available?

What can we do? We can continue to perfect our cal health services, doing a super job at home in ccordance with our means and facilities. Keep in touch with our Congressmen. Keep them informed of the progress we are making. They base their opinions on what is being done in their districts, but if we do not keep them informed on what we are doing, naturally they will be obliged to rely on information that is provided them on conditions in other districts.

Woman's Auxiliary

The first meeting of the Board of Directors was held on May 18 at the home of Mrs. Charles W. Goff, West Hartford, and general plans of activities for the year were discussed. The following projects will be undertaken by all counties:

Assistance in nurses recruitment.

Studies of State and National medical legislation.

Studies of prepaid medical plans.

In addition to these, each county will have several local projects which will be reported when their plans are completed.

The new Standing Committee chairmen are: Legislation, Mrs. G. Gardner Russell; Public Relations, Mrs. Paul Tisher; Finance, Mrs. Paul Brown; Postwar planning, Mrs. Winfield Wight; *Hygeia*, Mrs. Dewey Katz; Hospitality, Mrs. Joseph Howard; Publicity, Mrs. L. R. Morse; Revision, Mrs. Joseph Wool; Historian, Mrs. Creighton Barker; Bulletin Editor, Mrs. E. R. Smith; Editorial Board, Mrs. Paul S. Phelps; Parliamentarian, Mrs. James D. Gold.

Delegates and alternates to the 25th Annual Meeting of the Woman's Auxiliary to the American Medical Association were appointed as follows: Delegates—Mrs. Royal Meyers, Watertown: Mrs. Dewey Katz, Hartford; Mrs. J. Grady Booe, Shelton; Mrs. Ralph Gilman, Storrs. Alternates—Mrs. James R. Miller, Hartford; Mrs. J. W. Larrabee, West Hartford; Mrs. Joseph H. Howard, Bridgeport; Mrs. Stanley B. Weld, West Hartford.

The proposed revisions in the constitution and by-laws of the National Auxiliary were read and approved. Recommendations in regard to the proposed increase in dues were discussed and the delegates instructed.

At the next meeting the Board of Directors plan to invite the Advisory Committee to present to them the program of the year and receive their suggestions and recommendations. At the same time the standing committee chairmen will meet with their committees.

Hartford County

Mrs. Ralph Ogden met with her Board of Directors on May 13 in her home in West Hartford. They have already started work on Service to Home Bound Children, Care Packages, a Speaker's Bureau, a Medical Scholarship, assisting in Health Drives, promoting the sale of *Hygeia,* a study of National and State Health Legislation and a Health Day, so a very busy year is ahead of them. Their Medical Scholarship Fund has been established and since they made a profit of $714 from the rummage sale in February, a scholarship will be given this year to some deserving medical student or nurse from Hartford County. The trustees of the memorial scholarship were appointed by the Executive Board in the following order: Mrs. Norman Barker, 5 years; Mrs. Paul Phelps, 4 years; and Mrs. Paul Tisher, 3 years.

The one social event of the year, a luncheon bridge at the Tumblebrook Country Club, was held on June 8.

New London County

A meeting of the Executive Board was held on May 13 at the home of Mrs. Frederick B. Hartman, New London, with the president, Mrs. Julian G. Ely, in the chair.

Mrs. Joseph Wool was appointed chairman of the *Hygeia* Committee to replace Mrs. S. P. Tombari who resigned. Mrs. Wool was also appointed chairman of the State Revisions Committee.

A special Committee for a Student Nurse Fund was named by Mrs. Ely. Ways and means were discussed for raising funds to sponsor a student nurse who cannot pay the tuition for the Backus Hospital Training School in Norwich and the Joseph Lawrence School for Nursing in New London. The students will be selected with the cooperation of the director of nurses from both hospitals.

Fairfield County

A Board of Directors meeting was held on Tuesday, May 25, at the home of the president, Mrs. J. Grady Booe, Shelton.

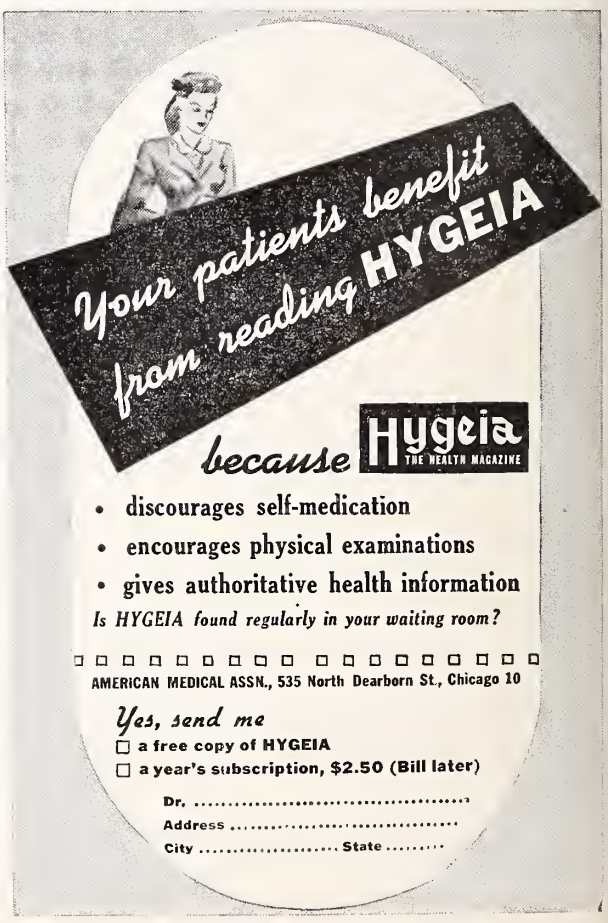
A letter was read from Mrs. Ruth Kenzie, director of rehabilitation and occupational therapy at Laurel Heights Sanatorium, expressing the appreciation of the patients for the movies made possible by a fund provided by the Auxiliary. It was voted to present a power motor sewing machine to Laurel Heights to be used in rehabilitation work from availal funds. Mrs. Greer and Mrs. Haberlin, chairman the Ways and Means Committee, have several pl for adding much more to this fund during the ye

Mrs. Edwin Trautman, chairman of Public Re tions, reported that on May 5 members of t Auxiliary attended a one day orientation course mental health at the Fairfield State Hospital, Ne town, where they enjoyed a tour of the tospit a delightful luncheon, and a movie of the p frontal lobotomy operation. Phases of mental heal were discussed by Drs. Oltman Green and Frie man.

Litchfield County

The Woman's Auxiliary had a luncheon meeti at Westleigh Inn and elected their officers as f lows: President, Mrs. Royal A. Meyers, Wate town; President-elect, Mrs. Donald Herman, Wi sted; Treasurer, Mrs. John R. Elliott, Canaa Secretary, Mrs. Louis Garston, Torrington; Aud tor, Mrs. F. L. Polito, Torrington.

Mrs. Robert J. Cook of New Haven was t speaker and discussed medical legislation.



OBITUARIES

Edward K. Parmelee, M.D.
1867 - 1947



Edward K. Parmelee, M.D., died at his home, 119 South Cliff Street, Ansonia, on December 12, 1947. Son of the late Calvin and Eunice Kibbe Parmelee, E. Parmelee was born in East Windsor on April 2 1867. After graduation from Enfield High School he entered Long Island Medical College, from which he received his diploma in 1889, and then interned at King's County Hospital, Brooklyn, N. Y. In 1891 he came to Ansonia where he practiced for 56 years, until about a year before his death from coronary thrombosis.

A charter member of the hospital staff of Griffin Hospital, Derby, he served this hospital as attending medical physician for many years. He served on the Ansonia Board of Charities, of which he was president from 1931 to 1934. Appointed medical examiner in 1925 to succeed Dr. William H. Conklin, he served in this capacity until 1946 when he resigned. An active Mason, he belonged to George Washington Lodge, A. F. and A. M., and to Mount Vernon Chapter, Royal Arch Masons.

He is survived by his wife, Isabel Tryon Parmelee; one daughter, Mrs. Arthur Wilkinson, of Ansonia; one son, Allan E. Parmelee, of Toronto, Canada; four grandchildren and one great grandchild.

His unusual obstetrical knowledge and obstetrical skill made him outstanding among his fellow physicians in this branch of practice. Genial, kindly, courteous, he was especially beloved by his patients and by his medical brothers. With the death of Dr. Parmelee there passes one more of that diminishing group of sterling men—the true family physician.

B. D. Tolles, M.D.

Randolph Raynolds, M.D.
1886 - 1947



Dr. Randolph Raynolds was born August 19, 1886 to Elizabeth Elliot Watrous and Edward Villette Raynolds, professor of comparative law at Yale University. After preparing at the Hotchkiss School, he received his B.A. from Yale with the class of 1909 and his M.D. from the College of Physicians and Surgeons, New York, in 1914. Very early in World War I he enlisted in the Medical Corps of the U. S. Army and was assigned to Mobile Hospital 39 (the Yale Unit). He received his commission as 1st Lieutenant in the Medical Corps while in

France. Following the war he returned to Connecticut where he was in general practice and at different times was engaged in the fields of physiotherapy, orthopedics and tuberculosis. In the later years he found his real field of interest, enthusiasm, success and accomplishment. As a friend has said, "He had the pride and joy and lasting satisfaction of turning his own bitter experiences into new life and hope and strength for others so that life as he went out of it was dear and desirable." While convalescing from pneumonia, he suddenly died on October 23, 1947 from a coronary occlusion. He is survived by his wife, Ellen E. N. Raynolds and two sons, Randolph, Jr., and Graham Nelson Raynolds. In a letter a short time before he died, he wrote:

"Now, toward the end of the course, I am doing a little bit in a branch of medicine which is perhaps the most estimable. To ease pain and relieve infirmity is good. To stop the inexorable advance of misery and hopelessness is better." His patients of recent years will understand. They will miss his counsel and the strength he gave to them. To his intimates, he has become a Victorious Life.

Arthur B. Dayton, M.D.

French Vaccine Useful in TB

A French vaccine has proven to be of great value in the prevention of tuberculosis, according to large scale tests which were made in American Indians and were reported at the 4th International Congresses by Dr. Joseph D. Aronson of the Henry Phipps Institute of the University of Pennsylvania. The tests were made with the cooperation of the Office of Indian Affairs and the United States Public Health Service.

For many years the Health Division of the Office of Indian Affairs has been interested in reducing the high tuberculosis rate among the Indians of the United States and Alaska.

The actual field work in these tests was conducted from 1935 to 1947, with a two year interruption because of the war. The study was started in the Pima Indian Agency in Arizona and was later extended to include the Shoshone and Arapaho Indians of the Wind River Agency, Wyoming, the Chippewa Indians of the Turtle Mountain Agency in North Dakota, as well as other Indian groups South Dakota and Alaska.

These Indian Agencies were chosen, Dr. Arons explained, because the Indians there are native their areas, and are cooperative and non migrato Their economic level is low, their housing is po and overcrowded, and they have a high tuberculo rate.

The vaccine employed by Dr. Aronson and h associates was originally introduced about 25 yea ago by two French scientists, Drs. Calmette a Guèrin and is named *Bacillus Calmette-Guèri* usually called *BCG* for short. It consists of a livi but weakened form of the bacillus which caus tuberculosis in cattle. Originally the use of a livi bacillus was opposed by American physicians. A cumulated experience has now proved that t objection is unfounded and that BCG vaccine harmless.

The vaccine was administered to more than fiftee hundred Indians, while a similar group was le unvaccinated for comparison. The two groups we not isolated or separated and were re-examine annually for a period of 9 to 11 years by means c chest x-rays and tuberculin tests. The death rat from tuberculosis was nine times as high in the u vaccinated group as it was among those who ha been vaccinated. The amount of sickness due t tuberculosis was almost three times as high amon the unvaccinated Indians as it was in the vaccinate group. Among 123 newborn Indian babies wh received the vaccination there was not a singl tuberculosis death during 6 to 8 years of continuou observation.

These facts demonstrate that BCG vaccine is a effective and dependable means of preventin tuberculosis.

Dr. Aronson's observations are regarded as im portant because of the large scale on which th work was conducted and the long period durin which the individual persons were kept under ob servation. Although BCG vaccine had been give to millions of people in many parts of the worl during the past 25 years, many of the earlier test were not extensive enough to yield definite evidenc as to the value of the vaccine.

The observations reported by Dr. Aronson ar believed to represent one of the most impressive and conclusive proofs that BCG vaccine is effective.

SPECIAL NOTICES

CLINICAL CONFERENCE OF STATE VA MEDICAL SOCIETY

ponsored by the Connecticut Veterans Association Med- Society, the following clinical conferences will be held ring July at the Veterans Administration Office, 355 Fair- d Avenue, Bridgeport:

y 7—Traumatic Injuries to the Knee Joint

Anthony Camarda, M.D., Assistant Surgeon, out-Patient Clinic, Hospital of the Special Surgery, New York City

y 14—Herniated Intervertebral Disc

Irving J. Sherman, M.D., Chief in Neuro-Surgery, St. Vincent's Hospital Bridgeport

y 21—Vasomotor Rhinitis

Eugene H. Walzer, M.D., Bridgeport

y 28—Bronchiectasis

Maxwell J. Antell, M.D., Associate Physician, St. Vincent's Hospital

All of the conferences are scheduled from 8:30 to 9:30 M. on the dates indicated.

AMERICAN COLLEGE OF SURGEONS

The thirty-fourth Clinical Congress of the American llege of Surgeons will be held in Los Angeles, with dquarters at the Biltmore Hotel, from October 18 to 1948. The program of scientific sessions on subjects in fields of general surgery; eye, ear, nose, and throat gery; gynecology and obstetrics; urology; and orthe- lic, thoracic, plastic, and neurological surgery, will be plemented by operative clinics in hospitals in Los An- es and vicinity by showings of operations by television motion pictures, and by a four-day hospital standardiza- n conference for hospital personnel, according to Dr. lin Abell of Louisville, chairman of the Board of Regents the College. There will also be extensive technical and entific exhibits.

Dr. Donald G. Tollefson of Los Angeles is Chairman of Committee on Arrangements for the Clinical Congress.

Association of Tumor Clinics Elects

At the annual meeting of the Association of Con- cticut Tumor Clinics in Fairfield the following ficers were elected: Francis Sutherland of Tor- ington, chairman; Robert Tennant of Hartford, cretary. The members of the Executive Com- ittee: Louis G. Simon of Norwalk; Edward Otten- imer of Willimantic; and Averill Liebow of New aven.

OUR NEIGHBORS

New York

A bronze bust of Walter Reed, conqueror of yellow fever, was unveiled at the Gould Memorial Library on the New York University campus on May 20. The bust is the work of Cecil Howard, American sculptor who has just been honored with the Legion of Honor by the French Academy.

COMMUNISM DEFEATED IN NEW YORK COUNTY SOCIETY

Ernest P. Boas was defeated for the position of president-elect of the Medical Society of the County of New York in a record breaking number of ballots cast at the annual meeting on May 24. It was a defeat for the radicals since Dr. Boas is chairman of the lobbying group known as the Physicians Forum, Inc., and is or has been a member of 8 Communist-front organizations. Incidentally, to show how this group is hand-in-glove with the Federal Security Administration, Secretary Ewing refused the Louisiana State Medical Society a delegate's pass to the National Health Assembly recently convened in Washington and then invited at least 13 members of the Physicians Forum, all of whom favor compulsory health insurance.

Rhode Island

Insurance Economics Surveys, in quoting *The Christian Science Monitor*, gives the reasons why the Manufacturers Association of Rhode Island objects to the cash sickness insurance system in that State. Here they are:

1. It is a form of state socialism and as such is opposed not only by industry, but by the medical profession. 2. It allows for a duplication of payment for workmen's compensation and from the cash sickness fund simultaneously. 3. It is a temptation to employees to increase absences from work, to the malingerer to stay home and draw pay, to the quack doctor to increase his clients by making a racket of the law. 4. Insurance companies report that it has increased workmen's compensation costs in Rhode Island. 5. It has never been safely and soundly solvent. 6. Once "on the books" it is hard to improve the law and there is danger that amendments may be passed that will make the law even

more unsound. 7. The law is so cloaked in secrecy that the employer has no opportunity to know who in his employ is the malingerer and who is honestly drawing his compensation. 8. Although labor is footing the bill to start with, industry may be asked to "kick in" if the fund is threatened with permanent insolvency.

NEWS
from County Associations

Fairfield

Joseph P. Leone, M.D., former medical director of the Delaware Hospital, Wilmington, has been appointed administrator of the Norwalk Hospital by the Board of Directors of the hospital, it was announced today. Dr. Leone will assume his duties at the Norwalk Hospital on July 1, when the resignation of former administrator Robert N. Brough becomes final.

The newly appointed administrator has had 19 years of experience in hospital administration in addition to his training as a physician. The Board of Directors feel that he is well qualified to fill the position vacated by Mr. Brough.

Middlesex

On April 8 the annual meeting of the Middlesex County Medical Association took place at the Red Coach Inn in Cromwell. Election of officers resulted in the following: President, Philip Schwartz, Vice-President, F. Erwin Tracy; Clerk, Norman E. Gissler; Delegates to the State Medical Society, William E. Buckley and Jessie W. Fisher.

During the course of the meeting Samuel C. Harvey addressed the society on "The Prepaid Medical Plan." Stanley H. Osborn made some remarks on the threat of state medicine. After the business meeting and dinner, Gerald Klatskin addressed the Society on the "Reaction of Liver Function Tests." This learned dissertation was well received by the society.

On Tuesday, April 13, the Central Medical Society had a joint meeting with the Middletown Scientific Association and listened to a lecture on the "Electronic Microscope."

Congratulations to Jessie Weston Fisher on her election as vice-president of the Connecticut State Medical Society. This is an honor well deserved by Dr. Fisher. She has been active in medical circles for well over 50 years and has served the Connecticut Society long and faithfully as a delegate to the State Society. It is infrequently that Middlesex County is so honored and certainly there is no one who is more deserving of this recognition.

New Haven

Abraham Gelperin of Johns Hopkins Hospital, Baltimore, has been appointed director of the Bureau of Venereal Diseases, New Haven Department of Health. Dr. Gelperin was a member of the Health Department of Cincinnati, Ohio, from 1935 until he entered military service in 1942.

John F. Fulton of New Haven is the author of "The Early Years of Andreas Vesalius," read at the 50th anniversary celebration of the Ramsey Medical Society Library, Saint Paul, and published in *Minnesota Medicine*, February 1948.

John P. Peters of New Haven presented a paper on "Pregnancy and the Thyroid Gland" before the Conference on Normal and Pathological Physiology of Pregnancy in New York City on January 30. This paper was published in *The Yale Journal of Biology and Medicine*, May 1948.

Edward R. Smith of Meriden has been appointed instructor in surgery at Yale University School of Medicine. Dr. Smith is an assistant attending surgeon (on leave of absence) on the staff of the Meriden Hospital.

John A. Murphy, a practising physician in New Haven for almost 50 years, died at St. Raphael's Hospital on June 1. Dr. Murphy was a general practitioner.

A social gathering was held at the Waterbury Medical Society Building on May 20, at which time Drs. W. E. Wight of Thomaston and A. A. Johnson of Waterbury told of a recent trip to Europe, and showed many pictures taken in England, Belgium, Switzerland and Italy. Members of the Woman's Auxiliary served refreshments. Those present included physicians, their wives and friends, from the Waterbury area.

The Waterbury Heart Society, Inc., has been organized for the Waterbury area and will hold its first meeting on June 17, 1948. All those interested



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The June speaker for the regular meeting of the Waterbury Medical Society on June 10 was Arthur M. Master, cardiologist at the Mount Sinai Hospital, New York City. No regular meetings are held during the months of July and August.

At the last meeting of the New Haven Medical Association held June 2, 1948 a number of papers were given by the local physicians of the New Haven area and the following program was presented: The first of a group of case reports was given by Hyman A. Levin and was entitled "Hypertension in a Twelve Year Old Boy of Unusual Origin—Surgical Relief with Apparent Cure." The second paper was given by Nicholas LaFemina and the title was "Gunshot Injuries to an Unborn Child." The third paper was presenetd by John Mendillo and the title of the paper was "Complications in a Meckel's Diverticulum—Polyp with Gastric Mucosa, Intussusception, Intestinal Obstruction and Volvulus." There was a paper given by Joseph Weiner entitled "Allergy in Children: A Simulating Appendicitis; B: Vernal Catarrh." The last paper was by Orlando Pellicia on "Two Cases of Oompl alocele with Immediate Postnatal Operation."

This meeting was enjoyed by all members prese because of the unusual character of the case repor and secondly because it was given by members the local society. It was a grand success and mo of this should be tried in the near future.

A number of doctors were admitted to the Ne Haven Medical Association. The names are as fo lows: Morris Beauchamp, Donald Beckwith, Ben dict Biondi, John Catalan, Gervase Connor, Davi Conway, Russell Fuldner, William Glaser, Fre Green, Jean Hippolitus, Bernard Kartin, Pa Lavietes, J. Francis MacNish, John Milici, Harr Moss, George O'Brasky, W. S. Odom, Ralph Seve ino, Carter Stilson, and Paul Winer.

Harris B. Shumacker, associate professor of su gery at Yale, is leaving July 1 to become profess of surgery at the University of Indiana.

New London

The last meeting and scientific program of th New London County Medical Association was hel on Thursday, June 3, at the Uncas-on-the-Thame The speaker of the evening was Dr. Paul B. Young Free Hospital for Women, Brookline, Massachu setts, who presented a most interesting presentatio on a timely subject, "Early Diagnosis of Cancer the Cervix." A spirited discussion followed.

The W. W. Backus Hospital, Norwich, has jus been presented with a check for $2,000 to provid an electrocardiograph machine and a fluoroscop machine in memory of the Cadden family.

A meeting will be held in July bringing togethe the officers, trustees, councilor and program com mittee to formulate plans for the coming 1948-4 season.



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Tolland

Fred C. Collier, M.D., has been appointed health officer of Coventry to fill the unexpired term of William L. Higgins. Dr. Higgins has resigned because of ill health.

Windham

John G. Raymer announces the reopening of his office for the practice of surgery at 59 McKinley Street, Norwich. After 4 months confinement due to a fracture of the bones of his lower leg, Dr. Raymer is again able to get about.

Winston C. Hainsworth of Norfolk, Virginia, and of recent date of the Yale School of Medicine where he has been a resident in the pediatric service, has opened an office in Willimantic and entered into the practice of pediatrics. This marks the beginning of the first practice in this locality confined solely to pediatrics. Other men in this area have in the past, although being in general practice, had special interests in pediatrics. As a matter of fact, it is rumored that a second full time pediatrician intends to establish himself in the Willimantic area also.

NEW BOOKS IN REVIEW

CLINICAL DIAGNOSIS BY LABORATORY METHODS—A WORKING MANUAL OF CLINICAL PATHOLOGY. (Eleventh Edition.) *By James Campbell Todd,* PH.B., M.D., Late Professor of Clinical Pathology, University of Colorado School of Medicine; *Arthur Hawley Sanford,* A.M., M.D., Professor of Clinical Pathology, Mayo Foundation, University of Minnesota; Senior Consultant, Division of Clinical Laboratories, The Mayo Clinic; *with the Collaboration of George Giles Stilwell,* A.B., M.D., Division of Clinical Laboratories, The Mayo Clinic. *Philadelphia and London: W. B. Saunders Company.* 1948. 954 pp. with 397 fig. $7.50.

Reviewed by Louis P. Hastings

Since publication of the first edition, nearly 40 years ago, this book has been a standard for the medical profession and technical assistants. So familiar is this work that it is customarily referred to as "Todd and Sanford."

This edition shows the usual discrimination in choice of methods and inclusion of these advances which have proved useful and reliable. Clinical pathology has reached the point of using so many physical, chemical and biological methods that no single volume can hope to include them in detail. The authors have met this difficulty by giving accurate references to original articles which normally would be consulted by the careful worker.

One is surprised at the inclusion of some rather inadequate methods such as the use of Congo red for blood volume determinations and it is regrettable that no mention is made of the Fisher-Race nomenclature for the Rh subgroups. The latter bids fair to become a preferred usage. The expansion and rearrangement of the material on medical mycology is welcome and well done. The terminology is tabulated and the illustrations are excellent.

The practising physician as well as all concerned with laboratory methods will find this book quite up to its usual standard.

PRIVATE ENTERPRISE OR GOVERNMENT IN MEDICINE. By Louis Hopewell Bauer, A.B., M.D., F.A.C.P., Diplomate, American Board of Internal Medicine; Member, Board of Trustees, American Medical Association; President, Medical Society of State of New York, 1947-1948. *Springfield, Illinois: Charles C. Thomas.* 1948. 202 pp. $5.

Reviewed by Stanley B. Weld

Dr. Bauer's years of indoctrination as a practitioner of medicine, as a delegate to the American Medical Association from the Medical Society of the State of New York, as president of his State medical society, as a member of the A.M.A. Council on Medical Service and then as a trustee of the A.M.A. have served to furnish him with an overall picture of the problem of medical practice which few others have acquired. Since publishing this book Dr. Bauer has become secretary-general of the World Medical Association, further evidence of the recognition of his ability as a medical statesman.

This volume is easily read and should be readily understood by any one. The author briefly outlines the problem of medical care as it exists today, influenced by medical education, medical diagnosis, hospital costs, nursing care, specialization, fees, the cost of drugs, and the distribution of physicians in the United States. He recognizes three groups of people in our present social order, the group who would hold to the status ante quo in medicine, the one which would throw all of the present system overboard and adopt the paternalistic control of the federal government, and the group which recognizes the changing world


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d would keep what is good in our present system of dical care and replace the obsolete and outmoded.

The author very frankly presents the deficiencies in our sent system of medical care. He gives the facts about lth conditions in our country, refuting those who would tort statistics to suit their needs. He traces the develop- nt of the governmental control of certain phases of dical care and the socializing influences on the practice Medicine. He contrasts foreign medical systems with our n and presents a very concise outline of the growth of compulsory sickness insurance movement in the United tes up to 1946.

Voluntary insurance plans are discussed but very briefly, ch more space being allocated to a presentation of the grams of the American Medical Association, especially se developed during the past decade. The chapter on the ent proposed national legislation pertaining to medical actice is likewise very brief.

In the final chapter Dr. Bauer briefly summarizes the tire problem together with the solution as he sees it. favors voluntary health insurance, extension of hospital surance, consideration of insurance for nursing care and r expensive therapeutic agents, the passage of the Taft- ith-Ball-Donnell bill "to coordinate the health functions the Federal Government in a single agency," policing the medical profession by its own organizations, and ovisions for care of the chronically ill. Dr. Bauer would ep our present system of medical care, "revising and proving it where necessary, but not discarding it for a stem which is un-American and which has never given satisfactory results as our own anywhere in the world."

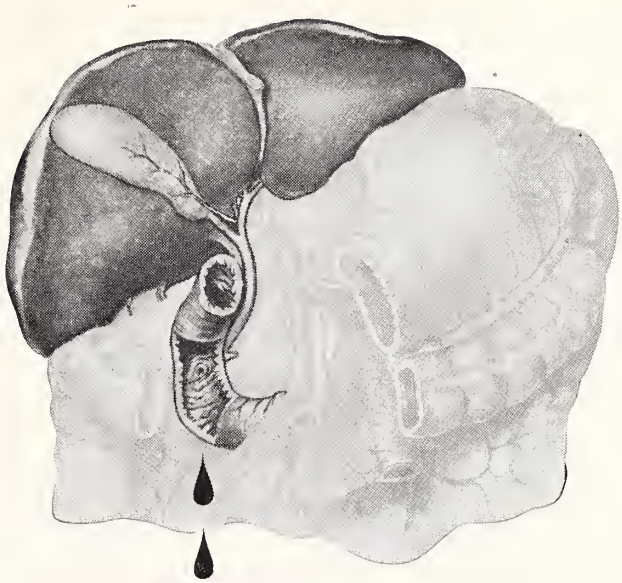
The appendix contains the Taft-Smith-Ball-Donnell bill d a short bibliography. Physicians would do well to rchase this book and study its contents. It is particularly lapted for the busy practitioner who has been unable to llow all the developments in this great controversy dur- g the past decade or two.

URGICAL DISORDERS OF THE CHEST—DIAGNOSIS AND TREATMENT. (Second Edition.) *By J. K. Donaldson,* M.D., F.A.C.S., Diplomate American Board of Surgery; Associate Professor of Surgery and in Charge of Thoracic Surgery, University of Arkansas School of Medicine; Surgical Staff, St. Vincent's Infirmary and Visiting Staff, Baptist Hospital, Little Rock, Arkansas. *Philadelphia: Lea & Febiger.* 1947. 485 pp. with 146 illus. and 2 color plates. $8.50.

Reviewed by WELLES A. STANDISH

This work is now in its second edition and contains 71 pages. The second edition contains all the qualities of he first with the addition of the fundamental advances ade in the field of thoracic surgery during World War I. Among these is the newer concept regarding decor- cation of the lung, which is discussed in some detail in Chapter V of Part I.

The author feels that there has been a great inclination n the part of most physicians to assume that only experi- nced chest surgeons are capable of handling major chest roblems at the operating table, and therefore the average hysician need not be seriously concerned with these prob-



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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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lems. It is the general practitioner, however, who is actually and primarily concerned with these, since it is he who first sees the majority of them; and it is he whom the patient depends upon primarily for diagnosis and advice. Surgical problems of the chest are numerous and every day problems, and in nearly every community there will be men who will handle more chest work themselves than has been previously customary.

This book has been written, with the primary object of filling the need of general practitioners and general surgeons, medical students, residents and interns. The text excludes unnecessary detail, statistical and historical reviews, lengthy controversial discussions and massive bibliographies. Some space has been devoted to surgical technique, which none but the experienced chest surgeon would attempt, but it has been included in the belief that it would enable the reader, even though he would not perform such operations himself, to evaluate more fully the logic of many difficult surgical procedures which he might otherwise consider as undertakings of unduly radical nature. Some of the technique maybe useful to capable general surgeons who should handle some of these problems in toto themselves.

Part I is devoted to inflammations, tumors, cogenital abnormalities of the thoracic wall; and thoracic injuries. Chapter VI of this part is a very clear and concise description of the physiology of the thorax. Part II deals with non tuberculous intrathoracic infections; pleurisy, including tuberculous empyema; pulmonary embolism and infarction; intrathoracic tumors and congenital abnormalities. Study of this part should make possible more accurate diagnosis and give a much clearer picture of therapy to the individual seeking to broaden his knowledge of intrathoracic disease. Part III deals primarily with the surgical therapy in pulmonary tuberculosis, which should be common knowledge to all, but tends to be limited primarily to those specializing in the disease. There is also discussion of postoperative pulmonary complications, resuscitation and inhalation therapy.

It is the feeling of the reviewer, that the author has accomplished his objectives and that this volume is an excellent single reference work regarding the chest.

HYPNOTHERAPY, A SURVEY OF THE LITERATURE. By Margaret Brenman, PH.D., Director of the Division of Psychology, The Menninger Foundation; Professor of Psychology, The Menninger Foundation Center of the Department of Psychology, University of Kansas and *Merton M. Gill,* M.D., Associate Psychiatrist, Assistant Director, Department of Research, The Menninger Foundation. *New York: International Universities Press.* 1947. 276 pp. $4.50.

Reviewed by GERALD V. RYAN

Surveys of literature are apt to be rather dull reference type of reading and often lack the personal touch and pragmatic content desired by the practitioner. This Fifth Menninger Foundation Monograph is a significant exception.

In 1944, as a service to psychologists and psychiatrists in the armed forces, the authors prepared a survey of the literature on hypnotherapy with a brief historical introduction and an adequate description of techniques of inducing and terminating hypnosis, as well as a discussion of the therapeutic applications and variations. The review was confined to the publications in the last half century, covering some 1,200 titles. The bibliography was selected "with an eye not only to pertinence but also to availability."

Repeated requests for reprints of this review resulted in the authors presenting it as Part I of "Hypnotherapy, A Survey of the Literature."

Four clinical studies, originally published elsewhere, constitute Part II: (1) A case of anxiety hysteria, (2) an hysterical psychosis in a 71-year old woman, (3) hypnoanalysis of a neurotic married woman, (4) a most interesting study of variable techniques used in the treatment of an only child of 14 years with self-starvation and compulsive hopping, emphasizing the closeness of such states to psychotic regression and the possibility of improving the very guarded prognosis usually given the severe anorexias. These clinical studies partially indicate the operationally effective field of hypnotherapy.

A condensed version of "The Use of Hypnotic Techniques in a Study of Tension Systems," Dr. Brenman's doctorate thesis, is presented as the third section of the monograph. This is a research investigation using hypnosis as a tool in an attempt to illustrate one type of experience aimed at bridging the gap between general psychology and analytical theory, between clinical observation and experiment.

The authors are conservative, the approach is careful and impressive, and the volume is liberally interspersed with direct quotations.

Apart from the clinical material, one of the most valuable sections of the monograph is that on hypnoanalysis, one of the newer treatment methods of current interest to psychiatrists. Hypnoanalysis, using many of the Freudian concepts, including free association, a piece-meal disintegration of patient resistances, the phenomenon of age regression, and a reintegration into consciousness of repressed material is often a great time saver. The variations in this technique are multiple, the handling of the transference is important and posthypnotic suggestion or post-hypnotic amnesia is utilized in what Linder calls "the synthetic and re-educative redistribution of elements formerly exploited by the pathological processes." The authors believe that hypnoanalysis holds the greatest promise for shortened psychotherapy with the important factor of "insight" as a mechanism of cure.

Since the volume appears to have been assembled quickly, it suffers from the usual defects associated with this technique, including some repetition and a certain lack of coordination of clinical and theoretical material. As the authors state, they are aware of the inadequacy of the volume but have produced it under pressure. Part III is of limited interest and value to most clinicians.

This volume is recommended reading for professional psychotherapists and since hypnotherapy is currently utilized in the treatment of frigidity, vomiting of pregnancy, dermatological conditions, and other disorders, it will be of value to some physicians in other fields.

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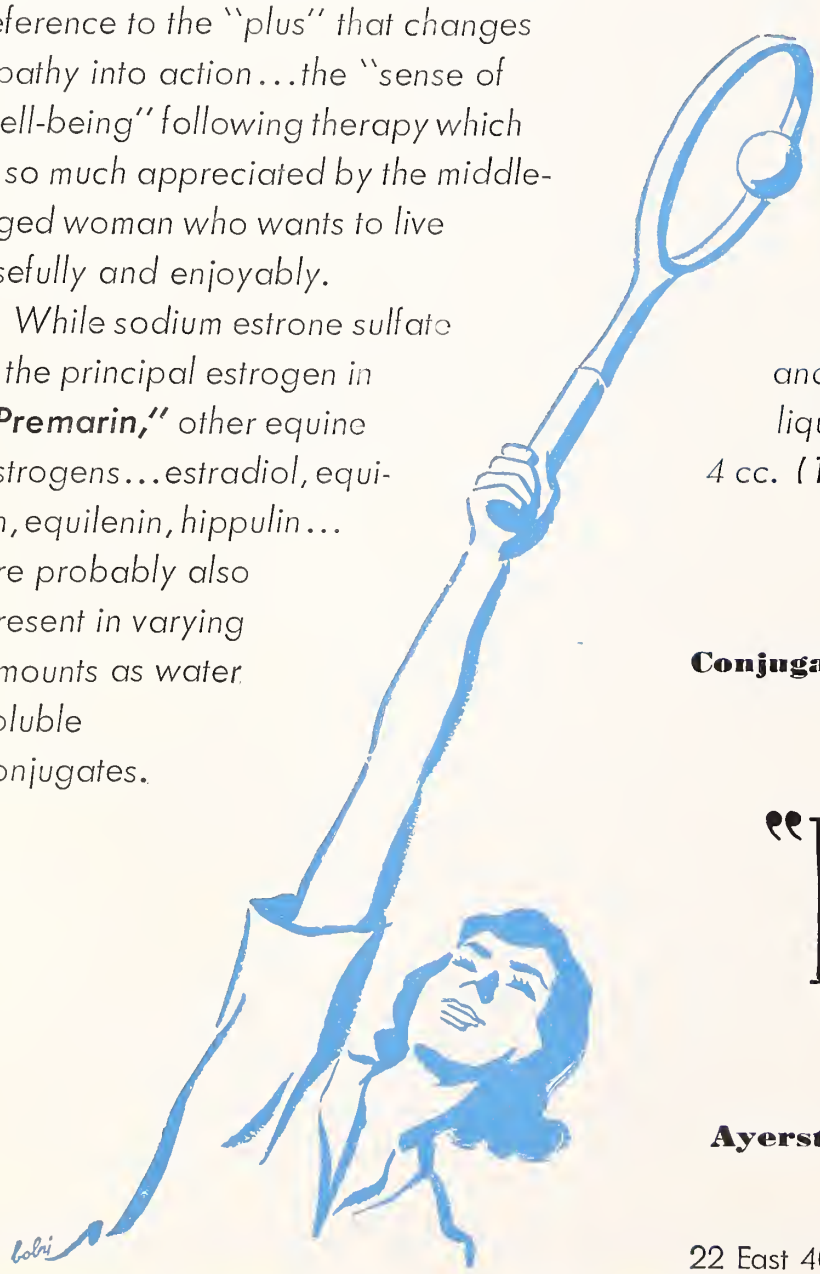
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SEASONAL HAY FEVER

Sidney W. Jennes, M.D., *Waterbury*

The Author. *Attending in Allergy, Waterbury Hospital; Director of Allergy, St. Mary's Hospital, Waterbury*

More is being written in both scientific journals and the lay literature about allergy in general and about hay fever specifically than about almost any other branch of medicine. The term "hay fever" has suffered much from misuse, and has outgrown its original meaning. It originally referred to symptoms of sneezing and profuse watery secretion from the nose and eyes that occurred during the summer, particularly at haying-time. The usage of this misnomer spread until hay fever came to designate such a symptom-complex regardless of the time of the year or the etiological factors involved, whether they be pollen, food or animal dander. For this reason, although the term is poor, custom has given it a permanent place in medical dictum.

Seasonal pollinosis or allergic rhinitis (seasonal) are much more descriptive and explanatory terms, the former indicating etiology and the latter etiology and pathology. Seasonal hay fever in New England has its usual range from April through September, with symptoms varying in intensity dependent upon factors that will be considered later.

The basic cause of seasonal hay fever is the plant pollens, the sex-element of the plant that is integral in fertilization. The responsible pollens differ in the various sections of the country both as to the type of pollen and the time of pollination. Physicians are most concerned with plants indigenous to their particular sections, but at the same time they must be cognizant of pollen flora in other sections of the country to which their patients may travel. Wodehouse[9] gives very complete lists of significant pollen-producing plants throughout continental United States.

The flora in Connecticut is much the same as that in the other Northeastern States. There may be a short time-variation in the onset and the end of the various pollen seasons between the State of Maine and of New Jersey, but little difference exists in the symptom-producing species. Not all plants are of allergic significance. Most of them play no part in producing symptoms of hay fever. In order for plant-pollen to be potentially allergic they must fulfill certain criteria set forth by Thommen[1] as the "Five Postulates." (1) The pollen must be wind-blown (amenophilous). (2) They must be produced in sufficient quantities. (3) They must be sufficiently buoyant to be carried considerable distances. (4) The plants producing the pollen must be present in sufficient numbers. (5) The pollen must be sensitizing or inherently capable of producing allergic symptoms.

In Connecticut the allergically significant species with which the physician should be concerned are in order of importance: (1) ragweed—small or low and giant or high, (2) grasses, (3) trees, (4) plantain. There are several of lesser or questionable significance, such as the artemesia, the chenopods and the amaranths. By far the largest number of individuals are clinically sensitive to ragweed. In a series of 340 patients with hay fever analyzed by the author, 87 per cent were found to be clinically sensitive to ragweed alone or to a combination of ragweed and some other pollen, 56 per cent to the grasses alone or in combination, 11 per cent to trees alone or in combination, and 4 per cent to plantain only in combination. There was consider-

able overlapping, some patients having clinical sensitivities to two, three or even four pollens.

Chronologically, the first pollens to appear in the air are those from the trees. These are sometimes designated as the early spring pollen. Hazel and alder, earliest of the trees pollinate the first part of April, followed by the maple, elm and poplar. By the time these are disappearing from the air, late in April, the birch pollen first appear. Early in May we find the pollen from other trees—beech, ash, and later, oak. Oak ranks first and birch second in clinical importance, the two together responsible for over 75 per cent of the tree-pollen sensitivities. Birch is the chief factor in the early tree-season and oak in the later. As a rule the symptoms of tree-sensitive patients are of short duration, usually lasting 10 to 14 days, unless a patient is allergic to more than one of the tree pollens.

Plantain, a weed that is indigenous to England, is only a minor offender among the plant-pollens. The pollen of English plantain first makes its appearance in Connecticut about the middle of May and continues throughout August with a maximum density about the middle of July. It is rare to find a patient with symptoms due only to plantain pollen; plantain sensitive patients usually have symptoms due to grass pollen as well.

The grasses, which cause late spring and early summer hay fever, are much more important than plantain and appear about the same time or just a little later. The most significant grasses in the northeast are the June grass, which pollinates the latter part of May and through the middle of June, and the timothy grass, which appears the end of June and may continue into the early part or even to the middle of July. Other grasses, such as sweet vernal, red top and Bermuda grass may be present, dependent upon the mixture of grass seed used in the particular locality. This factor, however, is of less importance than the natural spread of grass pollen.

The last but the most significant among the pollen to appear is that of the ragweed. The ragweed granules first appear between August 2 and August 12, but as a rule are not numerous enough to cause clinical symptoms until the end of the second week of August. The daily curve of ragweed pollination usually reaches its peak around Labor Day, dropping off gradually until about September 20th at which time the amount of pollen in the air is negligible. Both short and giant ragweed are found in this Stat but the short greatly outweighs the high in amour and importance. Short ragweed has also been calle dwarf ragweed, low ragweed and small ragweed Short ragweed is a grayish green annual, branched averaging from one to five feet in height, with finel divided leaves, and numerous long spikes of stam inate heads. The short ragweed abounds in the field along the edges of the crops, such as corn, along th roads and even city streets. Giant ragweed has als been called tall ragweed, high ragweed and larg ragweed. It grows in marshes and damp areas an may grow as high as 10 or 15 feet. Ragweed polle has been found to be carried through the air fo distances as great as 20 to 30 miles. The plants grov profusely and spread wildly. They are innocuou looking but are the cause of considerable sufferin and loss of time among those sensitive.

It is not uncommon for a patient with late sum mer hay fever to say that he is allergic to goldenrod Rarely is he correct, for goldenrod is such an un usual cause of hay fever that few allergists ever have the extract for goldenrod in their testing trays What actually occurs is that the patient has an attack of sneezing while in a field. Looking around he spies the pretty yellow spikes of goldenrod completely ignoring the unassuming ragweed plan that so frequently grows in the vicinity of the for mer. A similar misconception occurs in June. Hay fever during that month is frequently referred to as "rose-fever." The reason is that the height o the rose season coincides with the time of gras pollination. An attack of sneezing occurs when the patient bends to smell a rose. He naturally blames the attack on the aroma of the rose, when it is actually due to grass pollen that has been carried through the air and deposited upon the rose.

There are a few minor plants which must occa-sionally be considered in the etiology of hay fever They are the artemesia which include sagebrush muckwort and wormwood, the amaranths or pig-weed, and the chenopods or goosefoots. The pollen of these weeds appear in the air in very small quan-tities during the latter part of the summer.

In addition to the above, the molds may at times be responsible for symptoms of summer hay fever. Mid-western allergists have felt for a long time that members of the mold species are the cause of symp-toms of pollinosis in a high percentage of cases. Molds are much more common in the so-called

orn belt due to the fact that they thrive in the resence of the grains. In the East we are only now eginning to recognize their possible importance. The most significant molds, from the standpoint f abundance and sensitizing effect, are the hormo-endrum, the alternaria and the aspergillus. Of much esser importance, and present in limited quantities re the helminthosporium, the rusts and the smuts. Molds first appear in the spring during May, usually eaching their greatest density in July or August, ometimes having a secondary rise in September or October.

From the foregoing one realizes how valuable it s to be able to determine the pollens in the air at ny particular time. Such pollen surveys have been lone throughout the country for many years by arious workers, particularly Durham.[2] The author eported such a survey in Connecticut for the years 944, 1945 and 1946.[6] This may be accomplished by xposing glass slides daily that were previously meared with a preparation to hold the pollen gran-ules. The slides are placed in a shelter for protection gainst the rain. Several types of shelters are being sed and at present the shelter of choice is the type ecommended by the Research Council of the National Pollen Survey Committee, headed by Dr. Matthew Walzer.[3] A sampling device may be abricated which consists of 2 nine-inch, heavy, olished, stainless steel discs set horizontally 3 inches part and held with 3 struts. One inch above the enter of the lower plane is placed a slide holder nto which the slide fits snugly. The supporting rod f the apparatus, 30 inches long, rises from a tripod ase attached to heavy crossed boards to keep the pparatus firm. The slides are smeared with a mix-ure of 75 per cent petrolatum and 25 per cent nineral oil. A new slide is placed in the shelter at he same hour every day and studied through a nicroscope after having been previously stained by dye in order to make the pollen more readily dis-inguishable. The pollen of each species of plant as a typical appearance, which makes it readily dentifiable. In addition to the pollen, one may also ook for presence of the molds. Alternaria, hormo-dendrum, helminthosporium, rust and smut can be dentified on a glass slide. Agar plates must be set ut to find aspergillus.

A daily check on the pollen in the air during the ay fever season gives us much information. We earn to correlate the symptoms of the patient with he particular offending pollen. If no pollen is found on the exposed slide, we know there must be some other factor. The survey gives information as to the amount of the particular pollen, indicating when one might expect an aggravation of symptoms. We learn from the survey the effect of the weather—sun, wind or rain on the pollen count.

An examination of the patient is almost diagnostic. His appearance is typical. His eyes are injected and watery. He has a desire to rub them due to their itchiness. His nose may be red from scratching and rubbing. He has frequent paroxysms of sneezing and considerable watery discharge from his nose. In addition to itchy eyes and nose, he may complain of an itching palate or ear canals. A dry type of cough (not asthmatic) is not uncommon. He feels utterly miserable, irritable and nervous. There is no temperature elevation despite the name of the disease.

Examination of the nose may or may not be diagnostic. The typical appearance is that of a pale, swollen, boggy nasal mucosa. This is not always the case; often the turbinates may be pink or even red instead of pale, either from a complicating infection or irritation, such as nose drops. There is usually an abundance of clear watery secretion pouring from the nose. A smear made of the secretion will generally reveal an abundance of eosinophiles. Polyps may or may not be present in the nasal cavities. Hansel[5] believes that polyps are almost diagnostic of an allergic etiology, being due to a chronic edematous state of the mucous membrane, putting the structure under tension, so that by gravity the mucous membrane becomes pendulous and hangs down producing a grape-like appearance.

A complicating bronchial asthma is frequently found; in the East the figures reveal that approximately 35 per cent untreated patients with seasonal hay fever will ultimately develop bronchial asthma. In the Mid-west, the figures are higher, about 50 per cent. The symptoms of asthma may start within a day or two of the onset of the hay fever or may not appear until late September or early October.

The diagnosis of seasonal hay fever is dependent upon several factors: the type of the attack, its paroxysmal nature, the absence of fever, the season of the year, the repetition of symptoms each year during the same month. In addition, an examination of the patient will reveal the appearance as described above. Eosinophiles may be discovered in a nasal

smear. Further history may give additional evidence, a family history of allergy or a past history of some other allergy, such as eczema, hives, gastro-intestinal allergy or asthma. The patient may note that a particular food or dust or an animal produces a similar type of attack. He may remark that his attacks are usually worse on a dry, windy day or on a drive in the country or when he goes fishing in his favorite brook.

We have an additional means of corroborating the diagnosis. That is by means of skin testing. A minute amount of the various pollens are applied to the skin either by scratching the dry powder or by injecting a standard solution of the pollen into the epidermis. These techniques are known as (1) the scratch-method and (2) the intracutaneous or intradermal method. The former is less sensitive but a safer procedure when performed by someone other than an allergist. However, the intracutaneous technique has many advantages over the scratch. It is more sensitive, revealing more true positives. Walzer[1] feels that it is rare for a patient with definite clinical pollen hay fever to give negative skin tests. It is a safe method in experienced hands. The testing is performed starting with a weak extract (.0001 mgm. protein nitrogen) and increasing the strength by multiples of 10 until a definite positive reaction is obtained. The intracutaneous method permits one to titrate the patient and classify him according to his skin reactivity as Class A, B, C, D or E. This gives the physician an idea of the strength of the initial dose, the increment of increase, especially at the beginning, and the approximate top dose.

It is customary to test all pollen patients with the four major pollens: (1) a mixture of the two types of ragweed, (2) timothy grass which has the antigenic factor of the allergenic Connecticut grasses, (3) plantain, and (4) a mixture of the six most important trees—oak, birch, beech, poplar, ash and hickory. In addition it is usually advantageous to test the patient to the other inhalants and to the foods for other possible complicating allergens, as will be discussed later. Other sensitivities that may aggravate or prolong the symptoms may be discovered on complete skin testing.

In order to obtain the optimum results in treatment, the patient must be studied and observed quite carefully. The basic treatment consists of injections of the offending antigens in properly graduated dosage at intervals of 4 to 7 days. Th classification obtained from titration as describe above indicates the general schedule. However, eac patient must be adjudged carefully, the local re action after an injection indicating the subsequen dose. Three methods of injection therapy are use depending upon the time when the patient is firs seen. They are (1) the pre-seasonal, (2) the co seasonal, (3) the perennial. If the patient comes fo treatment early enough before the usual onset o symptoms, usually 2½ to 4 months, he is placed o pre-seasonal treatment, receiving injections every to 7 days. If the patient is not seen until after th onset of symptoms, co-seasonal treatment is neces sary. This consists of giving small doses of a weal extract frequently, even daily, if indicated, an increasing the dose very little if at all. After th season, and after the dosage has been increased to it tolerance, it is desirable to switch both the pre seasonal and co-seasonal patient over to perennia treatment. In this method injections of the main tenance dose are given every 2 to 4 weeks durin the entire year. A word of caution should be raise in handling Class A patients perennially; it can b done, but must be done very carefully and with du caution.

One must be careful to avoid constitutional re actions, that is, symptoms of urticaria, hay feve tightness in the chest or asthma immediately fol lowing an injection. This can be done if severa precautions are taken. A dose should not be in creased by too large an increment. Appearance o the injected site after each injection should b observed. Care must be taken in going from th largest dose of the weak solution to the subsequen small dose of the next stronger solution. Care mus be taken that the correct bottle is used. The plunge must always be withdrawn to be sure one is not i a vein. The syringe has to be scrupulously clean Particular care must be taken during the activ pollen season. Only a physician or well traine assistant under his watchful guidance should giv pollen injections. In case of a reaction, 0.3 cc - 0. cc (1:1000) epinephrine solution, which shoul always be available, should be given immediatel by subcutaneous injection.

In addition to treating a patient with injection of the offending pollen, other factors must be con sidered in handling seasonal hay fever. Other pos sible sensitizers must be eliminated or controlled

some of which might be a factor at any time of the year, and others that may be troublesome only during the pollen season. The latter are considered secondary sensitivities, that may be exacerbated only when the shock tissues are disturbed by the primary allergen, such as the ragweed, grass, etc. The secondary allergens may be animal danders, feathers or a food. We see patients who can play with a dog or eat a chocolate any other time of the year without nasal trouble, but during the pollen season such a contact may bring on an attack of hay fever. The animals should be avoided or removed from the house. Dust precautions should be instituted. Feather pillows should be covered with non allergic plastic or rubberized encasings. The offending foods should be eliminated from the diet during the particular pollen season. Wheat, being related botanically to the grasses, may be a secondary food factor during the late spring and early summer hay fever. The nuts, chocolate, corn, legumes or seasonal vegetables may be a factor during the ragweed season.

Local treatment may be resorted to for temporary relief. It is best to use simple or nonirritating nose drops that have a pH as near to 7.0 as possible, such as a solution of ephedrine sulphate (1 per cent) in normal saline. Nose drops that are too strong or too alkaline may paralyze the cilia or irritate the nasal mucous membrane. The nose drops may exert a boomerang effect when used too frequently. They give a temporary relief due to the immediate constrictor effect of the drug which is followed by a secondary swelling and turgescence, the period of relief becoming shorter with continued application and that of the secondary congestion becoming longer. One soon is dealing with a vasomotor rhinitis medicamentosa. We see this frequently during September and October, at the end of the ragweed season.

For relief of distressing eye symptoms a solution of ephedrine or epinephrine with or without cocaine or a substitute in boric acid solution is often of temporary value. Sometimes plain cold compresses applied to the eyes may have a beneficial effect. The use of dark glasses to cut down the glare of the light may be recommended.

Oral ephedrine or the ephedrine-like drugs are of little help. The same is true of oral aminophylline. Subcutaneous epinephrine and intravenous aminophylline are of slight temporary effect.

In 1946, the antihistaminics first became available for clinical trial. Benadryl and Pyribenzamine were the first, but did not become commercially available until the 1947 pollen season. This year many others are on the market, a total of 20 at the latest count, including histadyl, neo-antergen, antistine, thephorin, thenylene and hydryllin. Most of the antihistaminics are ethylenediamine derivatives. Basically their use goes back to the early work of Dale and Laidlow who in 1910 injected histamine into experimental animals and noted that the resulting symptoms corresponded with many but not all of the symptoms of anaphylactic shock. Lewis felt that the fundamental pathology is an edema reaction due to the release of histamine or a histamine-like substance which is irritating to the capillaries and fine arterioles. Since this has been accepted as one of the mechanisms in the production of an allergic reaction, there has been a long search for antihistamine drugs.

The so-called antihistaminics are gradually finding their place in our armamentarium of hay fever drugs. They are not specific cures nor permanent cures, but produce relative temporary relief. They are able to abort attacks in many cases and often give temporary freedom from symptoms for 2 to 4 hours. However several facts must be kept in mind when prescribing the antihistaminics: (1) tolerance may be developed if the drug is overused; (2) reactions are frequent, such as drowsiness, nervousness, insomnia, abdominal symptoms, etc. Often these reactions are so severe as to require discontinuance of the drug. (3) One may lose sight of the fact that we should look for the cause rather than simply treat symptoms; (4) nothing in the literature on the antihistaminics has shown that they will prevent complicating asthma as is usually the case if specific pollen injection therapy is instituted before the asthma first appears.

The experience of the author has been the same as that of most investigators. The antihistaminics are valuable as adjunctive treatment. They may be used at first while an investigation is being carried out to find the cause of the symptoms, but after the etiology has been ascertained they belong in the same category as such drugs as aspirin for the temporary relief of headaches or codeine for coughs. Specific injection therapy should be carried out and one of the antihistaminics used only if symptoms become unusually severe, at which time

a 25 or 50 mgm. tablet may be prescribed to help relieve the symptoms temporarily.

Anthallan is mentioned in passing only because of the publicity it received in the lay press. No further reports have been published to confirm the experience in the first small series of cases reported.

SUMMARY

A general discussion on the subject of seasonal hay fever is presented. The factors in etiology of hay fever in Connecticut are considered. Diagnostic measures and the clinical symptomatology are given. Finally methods of therapy are suggested, including specific pollen injections, local therapy and the use of the antihistaminics.

BIBLIOGRAPHY

1. Coca, Walzer and Thommen: Asthma and Hay Fever in Theory and Practice, Baltimore, Maryland, 1931, Charles C Thomas.

2. Durham, O. C.: Incidence of Ragweed Pollen in th United States During 1929, J.A.M.A., 1907, 1930.

3. Durham, O. C. et al.: Preliminary Report of the Nationa Pollen Survey Committee of the American Academy o Allergy on Proposed Standardization of Pollen Countin Techniques, J. Allergy 17:178, 1946.

4. Feinberg, Samuel M.: Allergy in Practice, Chicago, 1944 The Year Book Publishers, Inc.

5. Hansel, French K.: Allergy of the Nose and Paranasa Sinuses, St. Louis, 1936, C. V. Mosby Company.

6. Jennes, Sidney W.: Ragweed Pollen Survey In Con necticut, Conn. State Med. J. 11:339, 1947.

7. Tuft, Louis: Clinical Allergy, Philadelphia, 1937, W. B Saunders Company.

8. Vaughan, Warren T.: Practice of Allergy, St. Louis 1939, The C. V. Mosby Company.

9. Wodehouse, Roger P.: Hay Fever Plants, Waltham Mass., 1945, Chronica Botanica Company.

CONCEALED SOURCES OF LEAD PRODUCTIVE OF CHRONIC LEAD ABSORPTION AND INTOXICATION

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LEAD POISONING is probably the most important of the known toxic hazards incident to the development of our civilization. Today there are few industries that do not use lead or its alloys in some form. The expansion of industry during the past few decades is reflected in the tremendous increase in production and consumption of lead in the United States from 270,000 tons in 1900 to about 750,000 tons annually in the period immediately preceding World War II. A survey in 1940 by the United States Public Health Service of 16,803 industrial plants in 15 states showed 54 per cent of the 1,500,000 workers handling lead or its compounds. The actual decrease in the incidence of severe lead poisoning in the face of this enormously increasing exposure is due to the growing interest in industrial hygiene and the consequent widespread employment of adequate measures of safeguarding the health of workers in hazardous industries.

Lead poisoning can be divided into three characteristic clinical syndromes: (1) a group having predominantly gastro-intestinal disturbances, including lead colic; (2) another group having predominantly neuro-muscular disturbances, including peripheral neuritis and wrist drop; (3) one characterized by disturbances of the central nervous system, including lead encephalopathy. Usually most persons exposed to lead, under more or less controlled industrial conditions prevalent in this country at present, are considered mixed cases of relatively mild character. Colic usually develops before neuritis and cases of encephalopathy are extremely rare. In these mild, or so-called mixed cases, it is essential to understand that diagnosis is in the last analyses, a differential diagnosis.

One of the most dangerous features of lead poisoning is the insidiousness of its development. Absorption, excretion and storage of excessive quantities of lead may continue for many years without significant manifestations of intoxication. It is necessary to make a distinction between "lead absorption" and "lead intoxication or poisoning," the former meaning nothing more than absorption of lead into the body and the latter being the toxic

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age of lead absorption. The maximum allowable oncentration for water and beverages, for example, 0.1 mg. per liter. The average daily ingestion of ad for all individuals is somewhere between 0.3 to .6 mg. per day. Feces containing 0.2 to 0.4 mg. of ad may be considered normal. Kehoe states that daily fecal excretion greater than 0.6 mg. must be nsidered as abnormal. The upper limits of normal r lead in urine are 0.06 to 0.08 mg./liter. Blood ontaining from 0.06 to 0.1 mg./100 cc may be onsidered normal. In making a diagnosis of lead oisoning it must be borne in mind that the air we reathe and a great deal of the food and beverages e ingest contain lead and that normal concentraon limits have been established for body fluids nd excretions.

In industry lead is taken into the body mainly hrough the respiratory system and an atmosphere ontaining less than 1.5 mg./10 c.m. of air is conidered safe for workers in lead for the average ork-day.

Methods, processes and toxic exposures in the ndustries of Connecticut are well known to the ureau of Industrial Hygiene of the Connecticut tate Department of Health and Insurance Carriers. he following is quoted from the August 1947 issue f the *Connecticut Health Bulletin*, published by the tate Department of Health:

"Discovery of lead fume exposures in Connecticut ndustry has led to a carefully coordinated control rogram by the Bureau of Industrial Hygiene. Exessive atmospheric concentrations have been found n lead and lead alloy casting, in soldering and subequent grinding operations, in bullet and storage attery manufacture, in several operations in the anufacture of silverware, and in production using eramics containing lead borosilicate frits.

"The chemical, engineering, and medical resources f the bureau are employed to combat lead hazards. Detailed data on atmospheric lead concentrations, n operations involved, on air movement, and on ead absorption by workers as shown by the blood icture and lead in body fluids, are all correlated in naking recommendations. As atmospheric concenrations of lead are reduced below the maximumllowable limit of 1.5 milligrams per 10 cubic meters f air, emphasis is placed on the proper maintenance f control equipment and on strict continuation of good housekeeping practices. With the lead in the tmosphere reduced, when the lead absorption by workers falls within the normal range, the control program becomes more routine. Periodic medical examinations, usually made by a doctor at the plant, and occasional chemical and engineering check-ups are depended upon to protect workers from lead poisoning hazards."

Lead poisoning is a reportable disease in Connecticut. For the period from July 1941 through June 1947 there were only 24 cases of lead poisoning reported in Connecticut, of which 11 were classified occupational. Because of the difficulty in diagnosis, there is good reason to believe that there were many more cases of lead poisoning than those reported.

There are today as many fallacies concerning lead exposure as there are facts because of the difficulty in correlating exposure with clinical findings. To many physicians work with lead presupposes a lead hazard. There have been numerous cases of lead poisoning reported in children from eating or chewing paint from baby cribs and toys; when on careful investigation it was found that the crib and toy manufacturers did not use lead paint in their products. Other paint pigments are cheaper and make a harder enamel than is obtainable with lead. Today it is practically impossible to buy paint for indoor use containing lead.

Changes in the blood are among the most important and most constant manifestations of lead poisoning, although stippling may be misleading. This phenomenon has received a variety of designations, including stippling, punctate basophilia, and basophilic granulation. It occurs, although less consistantly than lead poisoning, in a variety of conditions, including pneumonia, anemia, leukemia, advanced malignancy, and following the administration of certain poisons, such as mercury, arsenic, anilin, nitrobenzol, carbon disulphide, etc. It should be pointed out that stippled cells usually disappear from the blood in 2 to 4 weeks after cessation of exposure to lead, but they may persist for a few months.

Aub suggests that stippling represents a general pathological reaction of the cells rather than a specific phenomenon attributable to the action of lead. Key states that stippling is a clumping of basophilic material and not precipitated lead. The blood of normal human adults rarely contains more than 1 per cent basophilic erythrocytes; the average is 0.4 per cent and 0.8 per cent. McCord and Holden state that in the absence of other pathology, any finding in lead exposed workers, of, or in excess of, 1.5 per cent at once suggests the probability of lead absorp-

tion. Findings in excess of 2 per cent or 3 per cent are to be associated with an increased imminence of clinical lead poisoning.

Laboratory findings:

1. Red blood count likely to be low (may be normal).

2. Hemoglobin may be low, diminished or unaffected.

3. No characteristic white blood count change.

4. Significant increase in number of stippled erythrocytes in peripheral blood.

5. Blood lead elevated significantly. No relationship established between concentration and severity of toxic episode.

6. Elevation of urine lead.

7. Elevation of lead in feces.

Patients with abdominal colic, blue gums, anemia, and stippled cells may not be suffering from lead poisoning. The most important criteria in the diagnosis of lead poisoning in industry is the history of exposure to concentrations of lead which are known to cause intoxication. In nonindustrial cases, the diagnosis may be much more difficult for the reason that the history may not include even the accidental ingestion of lead.

"Lead line" must be distinguished from: (1) bismuth; (2) stained teeth; (3) pyorrhea; (4) trench mouth; (5) gingivitis; (6) normal pigment of Negroes; (7) any dark skinned person. A favored site for the first appearance of "lead line" is in the external lingual edge of the gum opposite the bicuspids and lower molars.

Differential diagnosis:

Appendicitis, cholecystitis, cholelithiasis, renal colic, peptic ulcer, intestinal obstruction, spastic colon, acute gastro-enteritis, acute pancreatitis, coronary occlusion.

Neuritidies must be accompanied by other obvious evidences of lead absorption and intoxication. Encephalopathy must be accompanied by other evidences—differentiate from encephalitis (infection) neuro-syphilis, uremia, unlocalized brai tumor, carbon monoxide and mercury. (No chang in spinal fluid in lead.)

Treatment:

Prophylaxis.

Colic—10 cc of 20 per cent calcium gluconate.

Constipation: Saline cathartics.

Diet: Ample and well balanced.

Anemia.

Neuritis with palsy—prevent contractive malpos tion and prolonged disability.

Encephalopathy: Control cerebral edema—dehy dration.

Deleading:

In summarizing, lead poisoning as a clinical syn drome is essentially a toxic derangement of th gastro-intestinal tract on which are superimpose various functional disturbances of the peripheral an central nervous system, the type and severity o which depend largely upon the severity and dura tion of the lead exposure. (This does not includ the effects of lead absorption in the blood and bon marrow.)

Lead exposure has no meaning in the hygienic o diagnostic sense unless it results in the absorption o toxic quantities of lead.

The history of exposure to concentrations of lea in excess of the maximum allowable concentration the most important criteria in diagnosis. A detaile knowledge of industrial procedures and precise in formation as to conditions existing in a specific plan or operation is most essential for the interpretatio of the history. All is not lead that glitters.

BIBLIOGRAPHY.

Lead Poisoning by Cantarow and Trumper, Williams Wilkins Company, Baltimore, 1944.

Abstracts of Proceedings of Conference on Lead Poisoni by C. O. Sappington (Journal, Industrial Medicine, Janua 1947).

Connecticut Health Bulletin, August 1947; Published by Th Connecticut State Department of Health.

DIABETES AND HYPERTHYROIDISM

Effect of Propyl-Thiouracil on Diabetes Mellitus Complicated by Hyperthyroidism

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THIOURACIL and other thiourea compounds have proved to be amazingly effective in the control f thyrotoxicosis. Despite the frequency and sever- y of toxic side-reactions these drugs have been sed extensively but with considerable trepidation nd with close observation of the patient under reatment. The profession had generally become earful of thiouracil. However, its use especially in ne preparation for thyroidectomy, was attended vith such smooth postoperative convalescence that ne physician found himself in a dilemma whether o gamble with thiouracil before surgery, or a pos- ble thyroid storm after surgery. Thiouracil more requently won the toss because surgeons were npressed more and more with the ease with which hese patients responded to thyroid surgery. The readed postoperative thyroid crisis had been elim- nated.

And now propyl-thiouracil has become available, nd with it has gone the bête noire of earlier anti- hyroid therapy. This newer derivative of thiouracil as been found to be even more effective, possessing ll the desirable attributes of thiouracil, with but ttle of its toxicity in therapeutic doses. Toxic eactions are said to be few and far between, and enerally mild. We have as yet not encountered any oxic reactions, but we are on guard. As a result, ropyl-thiouracil has gained wide use not only pre- peratively but also in the medical treatment of hyrotoxicosis and other instances of hypermetabo- ism, as well as in cases where, for therapeutic easons, it is deemed desirable to induce hypo- netabolism.

We have been particularly interested in the use f thiouracil and propyl-thiouracil in the treatment of thyrotoxicosis complicating diabetes; and since diabetes serves admirably as a barometer of happenings elsewhere, we have become aware of a physiological side-effect of thiouracil, which has an important bearing upon its use in hyperthyroidism with diabetes.

Contrary to expectations, diabetes in the hyperthyroid under thiouracil therapy does not necessarily improve with the general improvement of the hyperthyroid state. In fact, the diabetes may get worse, even though the hyperthyroidism be brought under control. We have come to expect that diabetes aggravated by an intercurrent complication, such as hyperthyroidism, will improve again when the aggravating factor is removed. But it has been observed from the start that some hyperthyroid diabetics under treatment with thiouracil improve both in their hyperthyroidism and diabetes, while others improve in their hyperthyroidism but not in the diabetic state. Rose and McConnell[1] suggest that increased diabetogenic activity of the pituitary may prevent amelioration of the diabetes in such instances.

This is in striking contrast to surgical treatment of thyrotoxicosis. Surgical thyroidectomy, as opposed to "medical thyroidectomy" with thiouracil, is universally followed by a marked improvement in the associated diabetes, even to the point where the diabetes may altogether disappear.

Reveno[2] made the distinctive observation that in primary hyperthyroidism (Grave's Disease), an associated diabetes does not improve under thiouracil, whereas in secondary hyperthyroidism (toxic adenoma), the diabetes improves along with improvement in the hyperthyroidism. We have made similar observations on our service, and we have been further impressed with the increasing need for insulin in primary hyperthyroidism all out of proportion to the insulin requirement before

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From the Metabolism Service and Diabetes Clinic, Grace Unit, Grace-New Haven Community Hospital

thiouracil was begun. In one particular case on propyl-thiouracil the insulin dose was increased ten fold and maintained at 80 to 100 units a day without gaining consistently desirable diabetic control. Yet her hyperthyroidism has been completely subdued and she has gained much weight and strength and clinically appears well. The aggravation of the diabetes is quite marked in these cases and there occur frequent bouts of acute symptoms of uncontrolled diabetes with very high blood sugars and acidosis.

These challenging observations prompted an hypothesis to explain this striking disparity between the medical and surgical treatment of hyperthyroidism as it is discernible in the diabetic.

Thiouracil and its derivatives act to relieve hyperthyroidism by preventing the production of thyroid hormone. These anti-thyroid drugs interfere with the synthesis of thyroxin, but previously stored hormone is not affected, and the action of thyroxin already present in the gland is not inhibited. The normal thyroid with its large stores of hormone is, therefore, resistant to the action of these drugs. Toxic hyperplastic thyroid tissue, on the other hand, is very responsive to thiouracil and is rapidly blocked out by the drug. The toxic diffusely hyperplastic gland in primary hyperthyroidism lends itself to complete ablation with thiouracil, more complete than is possible surgically; for once the stored thyroxin is used up, no further thyroid hormone can be made available under the inhibiting effect of thiouracil.

However, a close relationship exists between the thyroid and other endocrine glands, and thyroid hormone is essential in order to maintain a normal thyroid-pituitary balance. In the absence of this hormone a compensatory increase in the secretion of thyrotropic principle from the anterior pituitary stimulates the thyroid gland to greater activity in an effort to produce thyroxin. This is manifested by the increase in the size of the thyroid that is frequently observed with these anti-thyroid drugs. But thiouracil prevents the synthesis of any further thyroid hormone, and so the pituitary is thwarted in its efforts, and a vicious cycle results in thyrotropic hyperactivity. When one pituitary factor is disturbed, other tropic factors of the pituitary are likely to be disturbed also. It may be reasonable to postulate that the diabetogenic and adrenotropic hormones of the pituitary are also activated, leading to an aggravation of the diabetes syndrome, on the one hand, and to insulin inactivation, on the othe with a resulting clinical manifestation of an i creased insulin requirement. Thus, even though th thyrotoxicosis in primary hyperthyroidism is r lieved by thiouracil, the diabetes is actually mad worse because of the complete blockade of th thyroid, with secondary hyperactivity of th pituitary, and resulting aggravation of the diabet state.

This concept can equally well be applied to ex plain the contrasting effectiveness of thiouracil i relieving both the thyrotoxicosis and the associate diabetes in the secondary type of hyperthyroidism Here the thyroid gland has both normal tissue an islands of hyperplastic tissue. The effect of propy thiouracil in this type of thyrotoxicosis is, in fac a "subtotal chemical thyroidectomy." The toxi hyperplastic tissue is blocked out by the ant thyroid drug but the resistant normal tissue con tinues to make thyroid hormone available. Th thyroid-pituitary balance remains undisturbed and as the toxicity of the thyroid recedes, the diabete improves along with it.

Similarly, in surgical removal of the thyroid enough tissue remains to furnish some thyroid hor mone to placate the pituitary, and here, too, th diabetes improves with the removal of the toxi load.

It would appear, therefore, that prolonged med cal treatment with propyl-thiouracil and relate anti-thyroid drugs is not suitable for the diabeti with primary hyperthyroidism (Grave's Disease) because of the adverse effect upon the diabetic stat The indications here are for thyroid surgery, afte preparation with propyl-thiouracil; and if surger is not acceptable, the concurrent administration o propyl-thiouracil and thyroid substance would ap pear to be indicated in order to allay pituitar commotion.

Dr. Allen I Saunders and Dr Anthony P Cibriano, Res dents in Medicine, cooperated in the clinical evaluation o thiouracil and propyl-thiourcil.

We are indebted to Dr. Stanton M. Hardy, Medical Direc tor, Lederle Laboratories, for the supplies of thiouracil an propyl-thiouracil used in this study.

REFERENCES

1. Rose, E., and McConnell, J.: Thiouracil Treatment o Thyrotoxicosis, Am. J. M. Sc. 208:561, 1944.

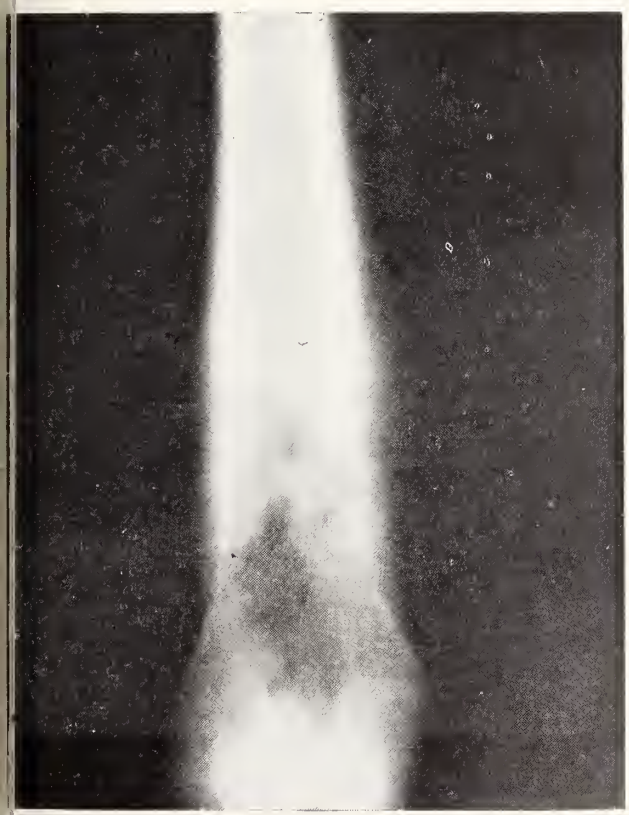
2. Reveno, W. S.: Thiouracil Effect in Diabetes Mellitu Complicated by Hyperthyroidism, Am. J. Med. Sc. 211:17 1946.

PERIOSTEAL OSTEOGENIC SARCOMA OF THE RIGHT FEMUR FOLLOWING TRAUMA — CASE REPORT

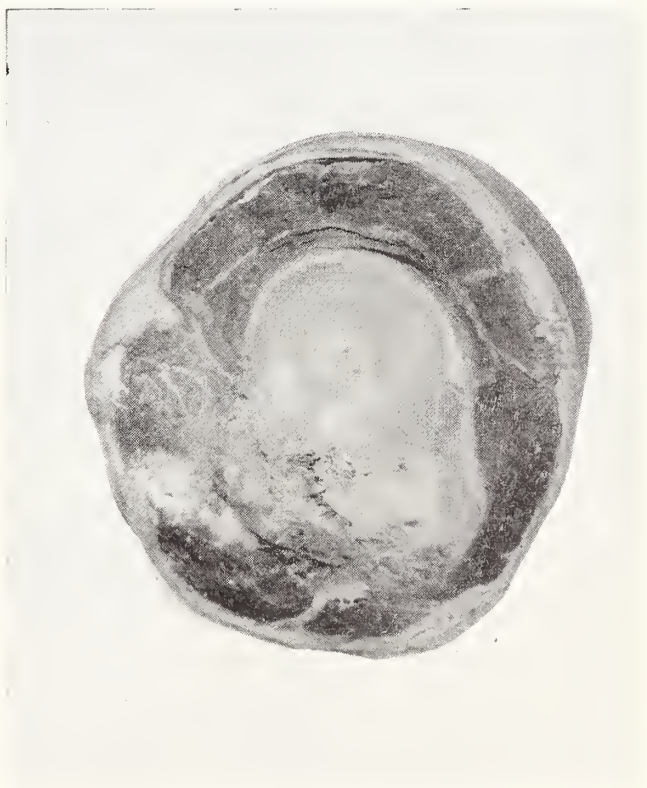
MAURICE R. MOORE, M.D., *Norwich*

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A BOY, age fifteen, was admitted to the Backus Hospital in August 1946 because of pain and swelling of the lower third inner aspect of the right leg. Two weeks previous the patient complained of pain in the right knee while walking. A few days later he noticed a slight swelling and tenderness



X-ray of Tumor Mass in Distal End of Femur



Gross Section of Tumor Mass

over the right knee. The pain increased in severity on walking and he had occasional pain in that area while at rest.

The patient injured this area three years previous when he was struck by a car while riding a bicycle. He had had no serious operations, accidents or illnesses other than that mentioned above.

Physical examination showed a well nourished and developed white male, fifteen years old, conscious, cooperative and well oriented. Head, moderately maculo-papular eruption on face, otherwise normal. Chest symmetrical, expansion equal. Lungs clear and resonant throughout. Heart, no irregularities or murmurs. Abdomen, no tenderness, tension or palpable masses. Extremities, moderate swelling and tenderness over the lower third inner aspect of the right thigh, slight pain over the lower third outer aspect of the left thigh, no redness, and no limitation of the motion of the left knee. Otherwise, essentially normal. An x-ray taken of the right lower femur showed considerable periosteal new bone in the lower third of the shaft and this presented a laminated appearance on the medial aspect. There was however, a small area of bone necrosis which was about 1 cm. in diameter adjacent to the medial cortex and there were also some similar smaller areas surrounding the large one. This could have been the result of an old chronic osteomyelitis and periostitis, but it was felt that it was very likely due to a primary malignant tumor such as Ewing's sarcoma. A film of the chest showed the bony thorax, diaphragm, pleura, heart and lung fields essentially



Tumor Mass × 50

negative. Eight days later another x-ray of the right femur was taken and showed essentially no change since the previous examination.

BIOPSY

A biopsy was performed three days later. Microscopic examination of the same showed a diffuse mass of cells which varied markedly in size, shape, and staining reaction. They were supported by a scanty, poorly formed, collagenous material. Mitotic figures were made out. There were masses of hemorrhage, bone and fibrin. This was considered to be malignant and the diagnosis of periosteal osteogenic sarcoma made.

OPERATION

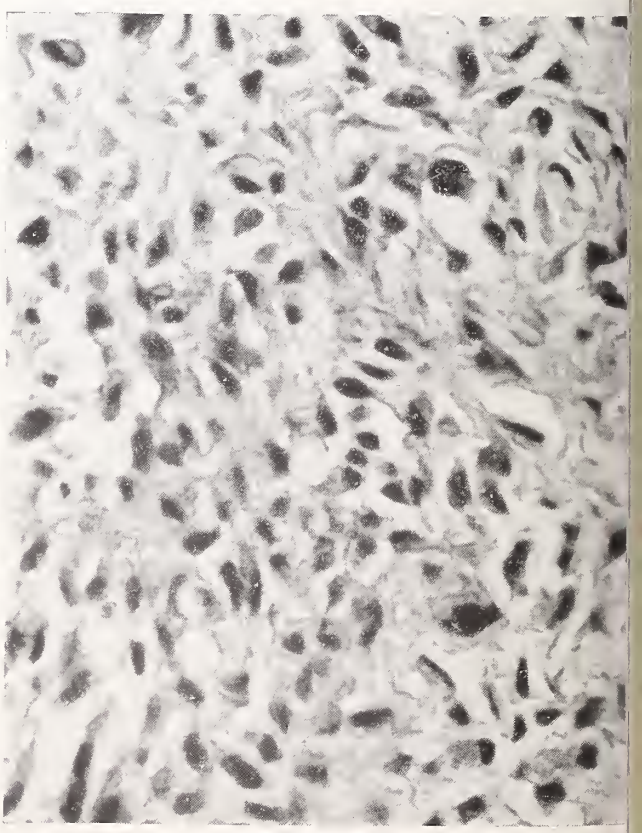
The patient's right leg was amputated ten days after the biopsy. Pathological examination showed the right leg amputated 30 cm. above the knee joint. No discoloration was evident. Three sections were made through femur. The first section was situated 3 cm. distal to the proximal extreme. The second section was 7.5 cm. distal to the first section. At both levels there was no evident pathology. A third section was made 9 cm. distal to the second section, and at this point a bony mass, 9.8 cm. in diameter, was found present. Normal bone structure was distorted and on the postero medial aspect, it w friable.

PATHOLOGICAL REPORT

The microscopic examination of the same show great masses of cellular tissue. The cells vari markedly in size, shape and staining reaction. Th were appearing in sheets and masses. There w edema throughout and large sinus formations. Th was early bone formation present. The patholog diagnosis was periosteal osteogenic sarcoma.

FOLLOW-UP

Crutch-walking, the therapy prescribed for t patient, was begun four days after the leg ampu tion, and the patient was dismissed from the h pital approximately two weeks after the operati The patient was followed monthly in the cripp children's clinic where on x-ray examination th was discovered a small bony spicule on the end the bone stump. He was re-admitted in May 19 for removal of the bony spicule. Since the ampu tion the stump had been sensitive, especially on t scar and the upper lateral anterior aspect of t stump. The pathological report after removal w exostosis. The patient was discharged a week af re-admittance, and again referred to the cripp children's clinic. His condition as of January 19 was entirely satisfactory.



Tumor Mass × 350

RUPTURED APPENDIX IN PREGNANCY — CASE REPORT

Sidney Vernon, Lt. Col., MC, *Fort Monmouth, N. J.*

THE prognosis of appendicitis with peritonitis in pregnancy has usually been guarded for the other and grave for the fetus. While a good result uld be expected if the condition were diagnosed rly and treated by operation, difficulties in both gnosis and treatment are greatly increased by e gravid state. First, the patient or members of r family are likely to discount abdominal pain ring pregnancy. Second, the physician has the ditional factor of pyelitis of pregnancy to evalue in his differential diagnosis. Yet the necessity r early correct diagnosis is even more nrgent in egnancy. For when peritonitis occurs it is more rious, and less localizing and self-defensive than the nongravid condition. In addition the presence the enlarged uterus and the resultant displaceent of the cecum makes the altered anatomy an ded factor of technical difficulty in the surgical ocedure.

Before modern chemotherapy, peritonitis meant evitable abortion for the fetus and a seriously ill other. However the advent of the modern antiterial agents has so altered the usual clinical havior that generalized peritonitis following apndiceal rupture in pregnancy can be successfully alt with and the pregnancy preserved. The following case illustrates this:

SE REPORT

Mrs. L. C., age 20, was admitted to Fort Monmouth ation Hospital about 10:30 P. M. on June 17, 1947. Thirty urs before admission she began to have epigastric pain hich later settled about the umbilicus and finally through- it the lower abdomen. During this period most of her time as spent in bed although she was up and around from time time. She ate "practically nothing." She vomited repeatly during the day before entering the hospital. Her last enstrual period occurred on April 19.

On examination she was found to be pallid and apprehenve complaining of pain in the lower abdomen. There was creased tone of abdominal muscles, with pain on pressure the left lower quadrant and markedly severe pain on ressure in the right lower quadrant. Rebound pain was very vere. White blood count was 18,400 with 91 per cent polys, per cent lymphocytes and 1 per cent monocytes. Urine as essentially negative. A diagnosis of acute appendicitis, rforated, with generalized peritonitis was made. The tient was prepared for immediate operation.

Under spinal anesthesia a McBurney muscle-splitting cision was made. The peritoneal cavity was opened. White ro-purulent fluid issued forth which was cultured. (The boratory reported "gram negative rods of coli group"). he appendix was removed, stump tied and mesentery was ed over it. The abdomen was closed in layers using no ains.

Postoperatively the patient was put on gastric suction which was continued for three days. She received streptomycin 0.5 grams every four hours for five days to a total of 15 grams. Penicillin 100,000 units was given every two hours using a total of 6,600,000 units. Her postoperative reaction was quite satisfactory, she was allowed sips of water within 24 hours, the abdomen having remained flat. The patient received 450 cc. of blood on the day of operation and 500 cc. of blood two days later.

The highest temperature recorded was 100.4 on the second day. Temperature and pulse were normal on the 5th postoperative day and remained so throughout her stay in the hospital.

She was allowed a liquid diet on the 3rd day and a soft diet on the 5th day. On the 7th postoperative day her sutures were removed; the wound was found to be clean and healing well. She was allowed out of bed on that day. On the 9th day the patient began to show spotting and she was put back to bed. She was allowed up again on the 11th day after operation and spotting again showed which required her to go back to bed.

On July 3 (16 days postoperatively), the patient having been comfortable and symptom free on complete bed rest, it was felt safe to allow her out of bed again. She tolerated this without untoward event. On July 7 she was getting up and around the ward. Her general condition was excellent and her appetite was good. It was also noted that her uterus was enlarging. Four days later she was allowed to leave the hospital and go home to normal activity.

In order to protect her against abortion the patient had been kept in the hospital until the 23rd postoperative day while progesterone was administered. A level was maintained by administering 5 mg. daily. Thereafter she was followed in the prenatal clinic. Throughout the period of prenatal observation her weight gain was satisfactory and blood pressure and urine were found to be normal. Spotting was noted at the expected menstrual dates, on two occasions, but the patient was given pranone immediately and put to bed and no effective uterine contractions developed.

On December 31, 1947 she was admitted to the obstetrical department of the hospital at 1:00 P. M. She stated that she had been having labor pains since 2:30 A. M. Examination showed at the time of admission a 2 finger dilatation of the cervix. She continued in labor through the evening and was taken to the delivery room at 1:00 A. M. January 1, 1948. With a right medial lateral episiotomy and low prophylactic forceps, a normal female weighing 5 pounds and 11 ounces was delivered. The episiotomy was repaired and the patient returned to the ward. The puerperium was entirely uneventful. Mother and baby were discharged on January 8 in good condition.

This case illustrates how modern antibacterial therapy and the use of blood and intestinal decompression can produce results formerly impossible. The comfortable postoperative course plus the successful continuation of pregnancy make this case of interest.

AN UNUSUAL CASE OF POST-PARTUM ANURIA

T. S. Evans, M.D., A. P. Cipriano, M.D., and H. Levine, M.D., *New Haven*

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Dr. Cipriano. *Resident in Medicine*
Dr. Levine. *Assistant Resident in Medicine,*
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The patient was a thirty-six year old married white female, gravida 2 para 0, whose expected date of confinement was November 4, 1947 and who was admitted to Grace Hospital October 11, 1947 in labor.

There was nothing remarkable to note during the progress of the patient's pregnancy and she was watched carefully by Dr. C. S. Hitchins for signs or symptoms of toxemia. The blood pressure remained normal—in the realm of 120/70-110/70—and the urine remained free from albumin throughout the course of her pregnancy. Unusual care and observation were practised, as the patient had had a previous spontaneous abortion at two months of gestation shortly following marriage at the age of thirty-four. No specific information can be obtained relative to the conditions and circumstances surrounding this episode. Systemic review, past history, and family history are noncontributory.

The patient continued normally in labor until signs of premature separation of the placenta became evident, following which the child was born dead. More specifically, labor began at 4 A. M. on October 11, full dilatation of the cervix was reached at 12:30 P. M., and the baby was born at 12:45 P. M. The placenta was delivered manually at 12:50 P. M. Total length of labor was 8 hours and 50 minutes. The condition of the fetus was not described. Numerous abrasions of the vagina were noted following the manual removal of the placenta, and these were repaired under pentothal anesthesia 45 minutes after delivery.

On admission, the temperature, pulse, and respirations were normal. The blood pressure was 120/84. The red blood count was 3.29 million with 70 per cent hemoglobin by the Dare method. The patient was Rh positive and type AB. No urine was obtained for study.

Approximately one and one-half hours after delivery, during the repair of the vaginal abrasions, the patient was given an infusion of 1,000 cc. of 5 per cent glucose in physiological saline followed by 250 cc. of lyophilized plasma, as signs of peripheral vascular collapse became evident. That evening the blood pressure was 120/92, the pulse 96, and the temperature and respirations normal. A transfusion of 500 cc. of whole blood in 500 cc. 5 per cent glucose in saline was started, together with the institution penicillin therapy in dosage of 30,000 units every th hours. Two hours following the completion of the tra fusion, the patient experienced a frank shaking chill wh lasted five minutes, without any rise in temperature pulse. The blood pressure remained 130/80. On the follc ing day, October 12, 1947, as the patient had not voided sii delivery (24 hours) she was catheterized and approximat 25 cc. of clear yellow urine were obtained. This specin was misplaced and therefore not examined. Following t procedure, an infusion of 1,000 cc. of 10 per cent glucose water with vitamins was started. This was repeated tw during that day, despite which there was no evidence urinary secretion. Later that day, the patient began to vo coffee-ground material and that evening another unit plasma was started, following which she suffered anotl shaking chill, which lasted ten minutes and was followed a rise in temperature to 100.4° orally.

On the following morning the patient was seen by I T. S. Evans, who found her to be markedly pallid a slightly edematous. There were no evidences of icterus a no gross hematuria was noted in the few cc. of ur secreted. The heart was not enlarged and the blood pressu was 155/85. The arms and legs were slightly edematous a the eye grounds revealed very slight arteriolar prominen Fluids and vitamins by vein were continued, and a red co that morning, two days after admission, was 3.02 milli with 57 per cent hemoglobin. White blood count was 16,8 with 86 per cent polymorphonuclears. The few cc. urine collected revealed plus-minus albumin, and a f wbc and rare rbc in the sediment. Blood chemistry stud that day showed the NPN to be 67 mgm., the uric a 2.5 mgm., total serum protein 4.02 gm., and sodium chlor 643 mgm. per 100 cc. blood. On that same day the pati was seen by Dr. Clyde Deming because of the relat anuria, a total of 90 cc. in 48 hours following a spontane delivery. His examination revealed the temperature, pul and respirations to be normal, and the blood pressu (systolic) was 130. Some edema of the hands and face v noted, and there was slight tenderness over the right kidn region. No reason for the apparent anuria was suggest and the recommendations were digitalization, caffe sodium benzoate gr. 7.5 every three hours, coffee per r tum, continued glucose infusion to 2,500 cc. total fluid take/day, sweating, and reconsideration of the Rh fact If the patient failed to void in 20 hours, ureteral catheteri tion was suggested.

On the third hospital day urinary secretion began to turn, and by the fifth day the total urinary output per

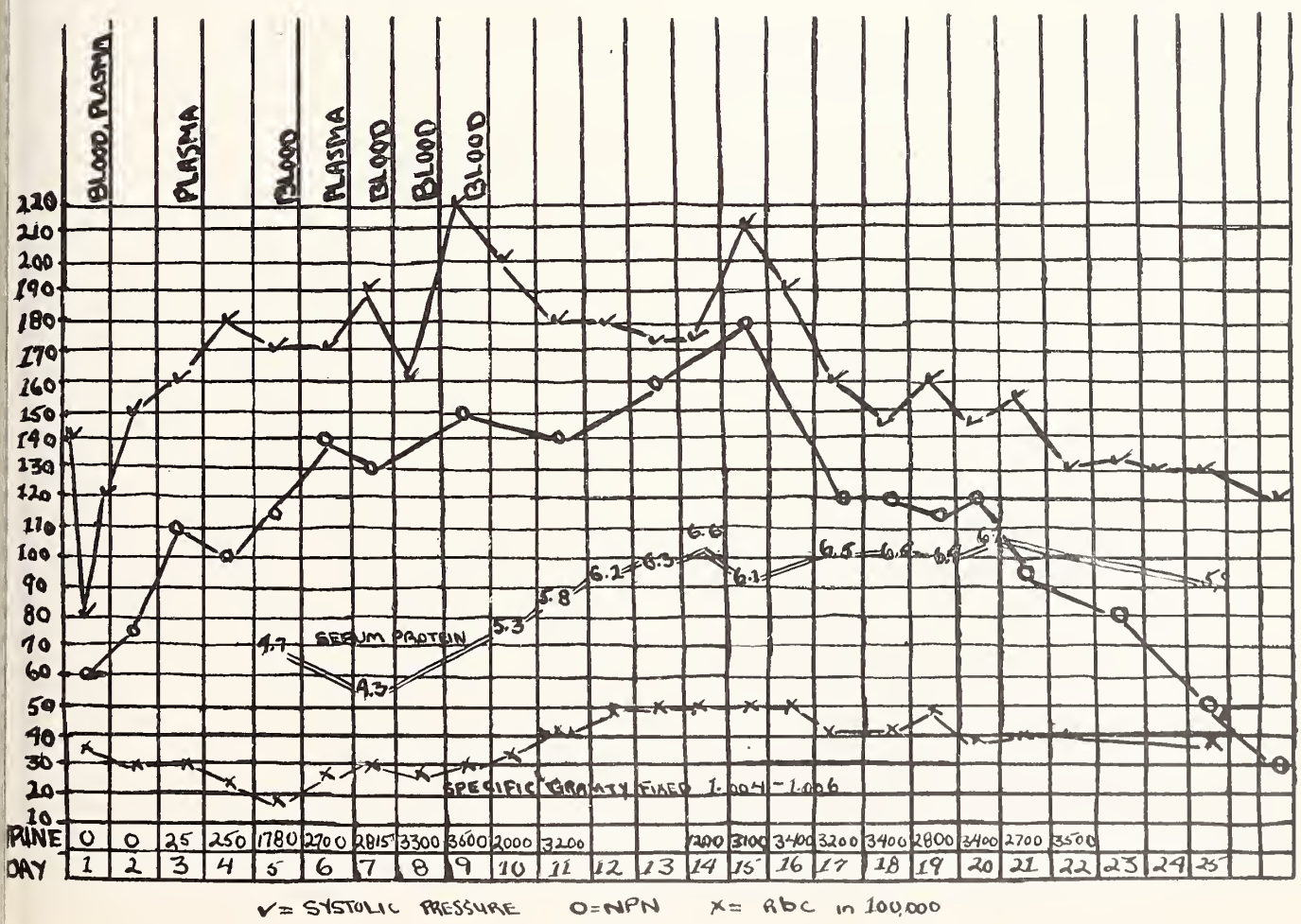
From the Medical Service of Grace-New Haven Community Hospital, Grace Unit

ours was 1,780 cc. However, despite the reestablishment of ormal excretory volume, the patient continued to vomit offee-ground material, to appear increasingly edematous and uporous, to hiccough constantly, and to manifest a pro-ressively rising NPN, which had reached 104 by the fifth ospital day. The blood pressure pursued a parallel course, sing to levels of 180-200/90-110. More blood and plasma ere given, so that by the seventh day she had received a otal of 5 transfusions and 3 plasma infusions.

From the sixth hospital day forward, the total daily rinary output gradually increased to a level of 3,000 cc. er day. However, the specific gravity of the nocturnal out-ut (450-500 cc.) was measured daily and it never exceeded 010. Daily urinalyses showed in addition to the low specific ravity two to three plus albumin, rare rbc's, and many bc's with clumps in the sediment. Casts were never seen, nd urine culture revealed the presence of B coli. The NPN ontinued to rise until a maximal level of 180 was reached n the fifteenth hospital day, and throughout this period he patient continued to manifest clinical symptoms and gns of severe azotemia. From this day forward there was rogressive fall in the NPN and blood pressure, accom-anied by regression of the signs and symptoms of her zotemia. On the eighteenth day an intravenous PSP test as reported as showing 22 per cent excretion of the dye n one half hour. For the obvious urinary tract infection ith the colon bacillus, the patient was given urotropin with odium acid phosphate. Improvement continued, and she was discharged feeling well on the twenty-ninth hospital day. On the day of discharge the NPN was 50, and the urine showed a specific gravity of 1.006, one plus albumin, and scattered wbc's in the sediment. The blood pressure was 120/80.

COMMENT

A woman married at the age of 33. At 34 she had a spontaneous miscarriage in the 2nd month of pregnancy. Approximately 2 years later she became pregnant for the 2nd time, went through 8½ months of "normal" pregnancy being carefully followed by her obstetrician. At that time she had premature separation of the placenta, her baby was born dead. There was very short lived peripheral-vascular failure which lasted a matter of 2 or 3 hours. A transfusion was given to her. She was found to have azotemia (N.P.N. 60 mgm). Anuria developed and persisted for 5 days. Oliguria for a long period. Hypertension, anemia, hypoproteinemia, nausea, vomiting and edema without obvious cardiac failure developed and persisted for 19 days. Azotemia reached its peak of 180 mgm N.P.N. on the 15th day. While being treated with transfusions of blood and plasma, sweating, gastric lavage, enemas and



other supportive measures, patient improved and gradually returned to *apparent* good health.

CHRONOLOGICAL SEQUENCE

October 11 to October 13—complete anuria, gradually developing edema, hypertension. October 13 to October 15—oliguria. October 13 to October 30—increasing azotemia, nausea, vomiting, edema of the face, hands, arms and lower extremities, increasing drowsiness, increasing azotemia and hypertension. October 30 to November 7—decrease in all symptoms and gradually falling blood pressure, N.P.N. November 7—discharge. November 12 to November 20—acute respiratory infection. January 6—office visit with relatively normal examination.

Treatment consisted of 5 transfusions given in 8 days 2,500 cc., 3 plasma infusions given in 5 days 800 cc., infusions of glucose in saline 1,000 cc., and in water 1,000 cc. every day for 12 days. Gastric lavage with Wangenstein and indwelling Foley catheter ano enemas were the general measures applied. Special therapy directed by obstetrical service consisted of penicillin, ergotrate, codeine. Special therapy designated by G. U. service consisted of digitalis, coffee enemas, caffeine sodium benzoate, urotropine.

The clinical problems raised in this case were many.

ANURIA

1. Cause: was this due to transfusion? We think not. Although the onset came in close proximity to the first transfusion it also coincided with mild and short lived peripheral-vascular shock. There are many reasons for discarding transfusion as the basis for renal failure: (1) there was no evidence of hemolysis; (2) chill and fever were minimal and less than from plasma given later; (3) no hemoglobin or blood were found in the urine; (4) subsequent transfusions were given without incident of any kind. Was it due to peripheral-vascular shock? Certainly not exclusively due to this factor. It is true that the onset occurred with fall in blood pressure, but the fall was short lived and was followed by hypertension. Was it due to intrinsic renal damage? Yes, we think it was. The reasons for making this statement are: First—patient was old to have first baby. Second—she had had a previous miscarriage. This probably was a safety measure which did not operate in her second pregnancy. Third—the N.P.N. was high on the first day of hospital stay and before the onset of the anuria. Fourth—the specific gravit of urine was absolutely fixed over a period of days, 1004-1007. Fifth—hypertension was not pre ent during pregnancy nor was edema present. Bot occurred after delivery and after the episode anuria.

Was there an added factor of ischemia of th kidney simulating a crush injury with renal sh down due to crushing of the myometrium? Th is a very intriguing question and although th answer to it is not completely clear, it seems to that it may have played a considerable role in th development of the anuria. Other factors whic conceivably may have played a part in the develop ment of the anuria are penicillin, which has seeme at times to precipitate an allergic phenomenon r sulting in anuria, and pentothal anesthesia whic has been observed to cause peripheral vascul shock. In all likelihood a number of factors co tributed to cause anuria in this case. Without th underlying renal damage it is probable that neith the crushing injury of the myometrium, the pen cillin or the pentothal would any of these hav resulted in anuria, but it is easily conceivable th with this basic condition one of these or a com bination of them may have acted as a precipitatin cause.

TREATMENT

Since anuria followed the first transfusion an since the red count and hemoglobin were not at dangerous level during the first 4 days, the 2n transfusion was delayed until the 4th day when th red blood count, hemoglobin and serum protein fe to dangerous levels. It was then instituted wit some trepidation but with the feeling that it ha become an absolute necessity to replace blood an that failure to do so any longer might prove fata Plasma was given to help restore the protein lev during this 4 day period. Fluids were given t replace loss from vomiting and sweating. Sweatin gastric lavage and enemas were used to promote th excretion of nitrogen. Peritoneal lavage was co sidered but very slight improvement was note before this procedure was instituted. Adequate flui output occurred on the 6th day for the first tim

AZOTEMIA

This was already present on the day of admissio (N.P.N. 60 mgms per cent) and increased steadil until the 15th day, and then gradually subsided unt

reached 50 mgms per cent at discharge from the hospital and has since fallen to 30. Azotemia continued to increase for the first 15 days (9 days after the patient had begun to void large amounts of urine which had low specific gravity, and 6 days after normal blood count and serum protein levels had been attained). Increase and decrease of azotemia corresponded pretty closely with rise and fall of blood pressure. This was probably a fortuitous coincidence since, theoretically at least, azotemia if due to peripheral-vascular failure should respond in inverse proportion to the height of the blood pressure.

NAUSEA, VOMITING, DROWSINESS

These symptoms had an inverse ratio to azotemia and this relationship seems to us to have been one of cause and effect.

HYPERTENSION

This clinical phenomenon seems to have run a course more or less independent of anemia, azotemia and blood levels. It remained at the abnormally high level after all other alarming features had reached safe levels.

ANEMIA AND HYPOPROTEINEMIA

As would be expected these two factors seem to have corresponded pretty closely throughout the course of the illness, and as they rose to normal levels and were maintained there, azotemia began to subside. It is a moot question as to whether this relationship was anything more than incidental, but personally we believe that correction of both these factors played an important part in the recovery of the patient.

SUMMARY

(1) This patient first became pregnant at the age of 34 years and the pregnancy ended in a miscarriage.

(2) A second pregnancy occurred at age 36 and terminated in placenta-previa with the birth of a dead baby at 8½ months.

(3) Renal failure occurred on the day of delivery and the consequent anuria persisted for 5 days. The probable causes of this anuria have been discussed.

(4) The simplest of all renal functional tests is measurement of the specific gravity. It would seem wise to use this test in the early months of each expectant mother.

(5) The human body has enormous reserves of power to "rebound." It is our function as physicians to protect these reserves and to do nothing to hinder the natural reaction of the patient.

WHAT IS MENTAL DISEASE?

C. Charles Burlingame, M.D., *Hartford*

The Author. *President and Psychiatrist-in-Chief of the Institute of Living, Hartford, Connecticut*

Each of us, within his mortal experience, has an interest nearest and dearest to his heart; and few moments are more heartwarming than those that bring the opportunity to talk about that interest! I have been given to understand that the traditions of this Society bequeath me with that opportunity tonight. You will not be surprised to hear that I choose to talk about what is called *mental illness*. You may be surprised, however, to learn that I believe there *is no such thing* as "mental" illness per se—or perhaps I should say not only is there no such thing, but there never has been and never will be such a thing, except as it persists in our own ignorance!

The dramatic history of the so-called "mental" illnesses is shrouded in mystery, and shackled with fear and superstition. It is too familiar to bear repeating. The fact we must face today is that in the lay concept at least, diseases of the mind are still identified to a great extent with metaphysics and a mysterious unknown totally unrelated to diseases of the body. Most people still identify the treat-

101st Presidential Address, Hartford Medical Society, January 5, 1948

ment of mental disease with devious and dubious theories that are, at best, far afield from the beaten path of scientific progress pursued by the other branches of medicine.

This, in spite of the fact that more than a century ago pioneering medical men recognized the sphere of emotional illnesses as one of the greatest uncharted domains of scientific medicine! Right here in Hartford, over a hundred years ago, Dr. Amariah Brigham, then superintendent of what is today the Institute of Living, embarked on a study to establish the scientific relationship between the body and mind in mental diseases. He studied the pulse, made measurements of the head, studied the effects of body temperatures, and of body secretions. He searched for the answer to mental illness in the realm of science, not of metaphysics.

I believe the time is fast approaching, at last, when we will find that answer. I have long been convinced that "mental" illness without a physical recording is as non existent as "physical" illness without psychological components. The existence of somatic factors in emotional illness has not been completely established. With our still primitive, albeit improved, methods of physical diagnosis, we are still unable to identify the somatic factors in many mental diseases—but that does not deny the existence of the somatic factors! The weight of evidence is entirely on the other side.

When I first entered the field of psychiatry thirty-nine years ago, the mental disease we know as general paresis, or softening of the brain, was thought by many to be caused exclusively by psychological factors. By others it was believed to be an hereditary condition, and along with other mental diseases was charged up, without a qualm, to heredity, that much abused part of our past on which all human failings have been blamed in the absence of substantial knowledge. Then, a few years later, I had the pleasure of looking at the original slides prepared by Noguchi, which dissolved another pillar in the heredity structure by showing the disease to be syphilis of the cortex.

Incidentally, Dr. Joseph E. Moore was never given his due credit for being the original discoverer of syphilis as the cause of paresis. He believed the disease to be syphilis of the brain, and had identified the organism, in what was the spore stage, in the paretic brain. Noguchi was just lucky in later identifying the matured spirochete. Dr. Moore's part was finally given formal recognition at the annual meeting of the American Psychiatric Association in 1946, more than thirty years too late.

There have been other enlightening discoveries. Today we know that in the "mental" disease known as involutional melancholia, there is an endocrine imbalance, the correction of which promises to be a most important feature in the cure. As another example, I can cite schizophrenic patients with pellagra. With the cure of the pellagra, the schizophrenic symptoms disappeared. I have had similar experiences with patients who had long had malaria.

During the past few months, revelatory observations on blood have shown that in certain diseases including some psychiatric conditions, a sticky substance appears on the outside of the circulating red cells, causing them to agglutinate into masses. As a result the blood changes from a fluid state into a circulatory sludge which, among other things, interferes with the nutrition of the nerve cells. Certainly new understanding of impaired circulation in the brain will be of significance in the treatment of nervous and mental disorders.

At this very time, the psychiatric world is being rocked by discoveries being made in Stockholm by Professor T. Caspersson and his associates in cell research. Using an ultra-violet spectrum to distinguish the constituents of single brain cells, those men are finding, for the first time, important chemical differences between the nerve cells in the frontal lobes of normal persons and those suffering from various "mental" diseases, including schizophrenia and manic depressive psychosis. This may very well be the final push in dissipating the myth of those mental diseases that have long been termed *functional* for lack of a more definitive name! The next step, of course, will be to find a means of correcting the difference in the cells of the sick person, and while this is yet far from an accomplishment, the researchers have announced that a chemical has already been found that partly provides the answer.

The future holds additional promise in the treatment of a group of psychiatric patients who have largely resisted our diagnostic procedures and therapeutic methods up to this time.

Other recent findings have clearly indicated chemical variations in human blood in connection with strong emotions or a craving for alcohol. One variation was observed in persons whose pronounced emotion was *tension;* another in persons whose pronounced emotion was *anxiety;* and still another in

rsons whose outstanding emotion was *resentment*. though the substances responsible for the differ- ces have not yet been identified, we may interpret s as still another indication of the close body- nd relationship.

Scientists have also advanced the theory that the emical, nitrogen trichloride, used in the bleaching d aging of grain for white bread, is a "nerve ison" that may be causing mental disturbances man. It has already been shown to have a deleter- us effect on the nervous systems of animals. Who n deny that our road to future knowledge is being early blazed? In the meantime, our psychiatric tients cannot wait. Using all of our present day edical knowledge, we must examine them from e point of view of the human body as well as the man mind. In psychiatric cases, we must use all sound physical medicine as well as what we ychiatrists call "psychotherapy" to put the tients in the best possible condition to meet life.

Treatment may involve helping the patient to ake a more satisfactory *vocational* adjustment to esent day society. It may include helping him find *avocational* outlet for his emotions, or helping m develop along *social* and *recreational* lines, or ding in his development along *physical* lines. My vn personal belief is that psychotherapy, regard- ss of its form, is essentially personal tutoring. I so believe firmly that such personal tutoring ould assume a *practical* form with a very *practical* plication to living. The sum total of psycho- erapy is teaching the patient to live successfully a constructive member of society according to s psychological as well as his physical capabilities, d according to his psychological as well as his ysical limitations. A popular misconception is that ychotherapy, and even psychiatry, are synono- ous with psychoanalysis. This could not be farther om the truth. The procedure known as psycho- alysis is only one psychiatric technique. Only 10 r cent of the 4,000 members of the American sychiatric Association are psychoanalysts. Ninety r cent are not.

I have emphasized bacteria and physical trauma as uses of mental disease, but I would also warn gainst becoming so preoccupied with the physical tors in illness that we forget the psychological uses. Psychological or emotional trauma also akes a well person sick. Years of effort have at st brought back to attention the facts that psycho- logical trauma can even cause serious somatic ill- nesses, all of which have crystallized into today's popularizing of psychosomatic medicine.

As a matter of fact, we are well agreed on the omnipresence of psychological factors. Certainly emotional trauma has been purged of mystery. We can see, and what we see can make us happy, or sad, or angry, or disgusted. We can hear, and yet, except as there is a somatic recording, hearing is nonexistent; and so on. There is certainly no mystery about the relationship between emotional reactions and body chemistry. That connection is too vividly demonstrated by those imbibing cock- tails to be disputed! By the same token, we speak of "a good bedside manner" in our profession. What is "a good bedside manner" if it is not being in contact with the patient as a whole, and establish- ing a beneficial emotional state of mind? Why do we post a no visitors' sign outside the room of a critically ill patient if not because of our respect for that intangible entity which is *the emotional* factor in illness?

The old-time horse-and-buggy doctor appreciated the importance of psychological factors in illness— he compensated for his lack of scientific knowledge by using the simple principle of putting the patient's mind at rest. Now, the recent war has given us final proof. Any remaining doubt was erased by war- time studies that established, beyond a shadow of a doubt, the importance of psychological components on the rate of recovery from physical disabilities. Only a totally ignorant, or hopelessly bigoted, per- son would take the stand that emotional trauma or its absence have no significance in tipping the scales in the right, or the wrong, direction.

In treating sick people, in general medicine or in any specialty, the doctor must consider the psycho logical as well as the physical factors in illness. If the modern doctor fulfills his medical responsibility, he utilizes not only the principles of physical medi- cine, but also psychiatric principles, which were used so successfully in a simpler form by our horse- and-buggy predecessors. Toward this end, in com- mon with a great many others in my specialty, I realize and regret the hindrances propounded by the nomenclature that is peculiar to psychiatry. We are desirous of imparting psychiatric principles and knowledge to the other branches of medicine with- out this language handicap, and I think we are on the way to removing it. I believe that all the things

we know can be as fully expressed in the English language and medical terminology as they now endure.

The medical specialties and their responsibilities cannot be separated, even as the mind cannot be separated from the body, except by death. If you are a heart specialist, you cannot sit in your bailiwick treating hearts in total disregard for the psychological factors involved. I am a specialist in the emotions, but I cannot treat the psychological side of my patients without full respect for, and attention to, the physical. First of all, we are each of us doctors of medicine, and only secondly are we specialists in one or the other branches of medicine. You must be a psychiatrist of sorts, and I, to a degree, must be a practitioner of physical medicine. Again I say, you must be a psychiatrist of sorts, and I, to a degree, must be a practitioner of physical medicine. This is not to say that I would dissolve psychiatry as a specialty. The specialty of psychiatry is not going to disappear any more than the specialty of surgery is going to disappear. However, just as the general practitioner does a great deal of minor surgery and preventive surgery, so should a vast amount of early psychiatric treatment and preventive psychiatry be practiced by branches other than the specialty of psychiatry. In the years ahead, each of you is going to become very much more of a psychiatrist, and we psychiatrists are going to become very much more doctors of physical medicine. It is in the cards of medical progress.

Whatever tomorrow holds, one of the fine things about psychiatry today is that approximately 80 to 85 per cent of all mental illness lends itself to the intensive therapy that we already have! The tragic note is that a great part of modern psychiatric knowledge is not being made available to the vast majority of hospitalized mental patients, 90 per cent of whom are in State institutions. This dereliction is not the fault of those engaged in our great State hospital system. On the contrary, those medical men and their loyal personnel are the unsung heroes of present day medicine—witness the untiring efforts of the men in our own State hospitals to improve the care and treatment of their patients.

Any dereliction in the State hospital system can be blamed on the failure of the public to meet its obligation. We might blame public indifference, but more charitably let us say that the public is uninformed and does not realize its responsibility toward the mental! ill who fill 640,000 hospital beds in this country, constituting the greatest pub health problem facing our nation today.

I have been most unhappy about the recent ter encies to exaggerate the problem of mental ills, oversell the need for psychiatric service, and overclaim the effectiveness of present day psyc atric techniques. These tendencies, glamorizing a spectacularizing psychiatry, and foreign to seric scientific effort, have exerted doubtful good. Th have exerted very real harm by diverting attenti from the hard-pan problems in our State men institutions. The fact is that 640,000, or more th half of the nation's hospital beds are devoted psychiatric patients. That fact in itself is devastati enough, without any need for exaggeration to esta lish its importance.

Here in Connecticut, the men in our State h pitals are doing a miraculous job, without adequ monetary support. They will be, and have been, t first to admit the need for public interest and acti Yet the people of Connecticut are not unsymp thetic, or apathetic, or phlegmatic. Again and aga they respond to every appeal; but first they m be aroused to their responsibility. In the sphere medical care and treatment, the job of arousi the public must be taken on by the medical prof sion! Isn't it time we took a good look at oursel as members of the Hartford Medical Society to s if we are 100 per cent on our toes, and interesti ourselves in this medical problem in our State?

In the early 1800's, when our State could r boast even one hospital, a visionary young doct by the name of Eli Todd aspired to establish a h pital for the care of the mentally ill. The people the State were canvassed. By whom? By the medi profession! The response of the public, as record is an inspiring tribute to Connecticut interest mankind. Donations ranged from twelve and o half cents to $300. Someone contributed "a gr of New London bilious pills, market price, $3 Other contributions included two lottery tick with the value of five dollars each! You may kn that the hospital erected with those and other do tions from the people of Connecticut was the fi hospital of any kind in the State and one of the fi three in the entire country devoted exclusively the care and treatment of mental disorders. It today the Institute of Living in Hartford.

We also have in Greater Hartford the famo American School for the Deaf, founded by Rev. H. Gallaudet in 1817. In Hartford, Dr. Hor

Vells made an independent discovery of modern esthesia. Our own Hartford Medical Society is ne of the oldest organizations of its kind in the ountry, a year older than the New York Academy Medicine!

I could go on, but you know the story better an I. The medical profession and the people of nnecticut have always been in the vanguard of ogress. Today finds the public still responding ontaneously to every appeal in the interest of man need. Are we doing our part as the medical ofession to solve the medical problems in our ate, the most serious of which is in providing lequate psychiatric care and treatment?

I wonder how the average citizens in this State ould react if they realized that the State appropria- on for the care of mental patients in State institu- ons is on an average of $15 a week for each patient, compared to the average bill rendered for ward re in general hospitals, which averages well over 50 a week for each person? I wonder, further, if ne average person realizes that the bill for ward re in general hospitals does not include payment r doctors' services, which are donated; but in the tate mental hospitals, the doctors' services must ome out of the $15 a week appropriated from pub- c funds?

If the people of Connecticut were faced with nose and the other equally appalling facts in the tuation, they would soon move to correct matters. ut they must be appealed to, not by the handful f Connecticut psychiatrists, but by Connecticut hysicians as a whole. An aroused public will fol- w an aroused medical profession.

All persons who enter the State hospitals as atients are, almost without exception, originally ne patients of men in the other branches of medi- cine. Certainly professional interest should not cease at the door of the mental hospital!

Every member of the medical profession in this State should indeed count among his blessings not only the men in private psychiatric practice, but also the fine men of high professional aspirations in the State hospitals who are fighting their battles on the psychiatric front, and are refusing to give up in spite of discouragements! It is time that we stopped merely talking about mental illness as the greatest public health problem. It is time that we, as individuals and as a profession, started doing something about it. Every single doctor in the State should back the men in our State hospitals by making their problem his, using all of his influence as a professional man (a) to dispel the mystery surrounding mental illness, (b) to rouse the public to meet its responsibility toward psychiatric patients, and (c) to bring all of the psychiatric advances of the past three decades to our own public institutions.

But I have digressed. Returning to my original thesis, I will prophesy that many, if not most, of you men and women here tonight will see the day when mental disease is no longer looked upon as if it were an entity separate from the rest of medicine. It is already evident that there is no such thing as a purely mental disease, nor, for that matter, is there such a thing as a purely physical disease. It is all disease, and will be so discussed, studied, and treated by the medical men of tomorrow. I call upon each of you to join in attacking mental disease on an intelligent, sound scientific basis. The sooner we forsake thinking of mental and physical diseases as two separate things, the sooner we will be scientifically sound in one attack upon the greatest public health problem, mental illness, which does not even exist—per se.

REPORT OF AMA COMMITTEE TO STUDY NURSING PROBLEM

T. P. Murdock, M.D., *Chairman*

Mr. Speaker and Gentlemen of the House of Delegates:

Following the vote of the House of Delegates at the Annual Meeting in Atlantic City, Dr. E. L. Bortz, the President of the American Medical Association, appointed a committee of five to study the nursing problem in the United States. The members of the committee are Drs. Warren Draper, Howard Gray, Leland McKittrick, Donald Smelzer and T. P. Murdock. The Committee made a report of progress at the semi-annual meeting in Cleveland in January 1948.

Your committee has gone into the matter exhaustively and has explored all of the available sources of information. During the course of the study, conferences have been held with representatives of the American Hospital Association, the American College of Physicians, the American College of Surgeons, the American Nurses Association and various other nurses organizations.

We estimate that about 400,000 nurses will be required to care properly for the American people in 1949. This estimate is based on figures obtained from "Facts About Nursing 1946 and 1947" and from the report of the President's Commission on Higher Education.

In 1940, 38,000 students were admitted to training schools; in 1941, 41,397; in 1942, 47,500; in 1943, 53,074; in 1944, 67,051; in 1945, 57,000; in 1946, 30,899. It will be seen from this that during the period of the nurse cadet program the number was at an all-time high. Immediately after the war was over the number dropped about fifty per cent. This may be explained on the basis of patriotism or stipend—probably the former.

It is estimated that there are about 342,737 nurses now available. A bulletin issued by the Women's Bureau of the U. S. Department of Labor indicates that 550,000 nurses will be required to care for the American people in 1960 if current standards of nursing are maintained. It also states that to accomplish this 50,000 nurses must be graduated each year from 1951 to 1960. The largest number ever grad ated was 44,700 in 1947. This was the graduati class that entered training schools in 1944 with admission number of 67,051. The report of t Bureau further states that "this is a realistic apprais of possible attainment in a given period rather th what is ideally desirable." To obtain what is d scribed as "ideally desirable" would require twi this number. These are staggering and alarmi figures and tell American medicine a story of wh is before it in the years to come.

There is one ray of hope before the committe A questionnaire was sent, by the American Hospit Association, to thirty-eight hundred (3800) memb hospitals in 1947. Twenty-three hundred a seventy-six (2376) replied. Thirty-seven per cent these replied that they did not need more nurs The New England area was in greatest need.

The committee has studied the problem und these headings: (1) Immediate relief; (2) Propos training for all grades of nurses in the future; (The economic situation.

1. Regarding the first it has recommended th retired nurses, including married nurses, be r quested to fill in during the emergency. Throug the efforts of Dr. W. W. Bauer, and with the ge erous cooperation of the National Broadcasti Company, and the Advertising Council, a great de of publicity has been given this subject. Mar editorials have appeared in *Hygeia*, State and Cou ty Medical journals stimulating doctors to aid recruitment of student nurses and urging retir nurses to return to the fold. Personnel trained the job have been advised and used to supplem nursing services. *Trained* practical nurses und supervision are being used. Hospital administrato have been requested to use nurses only in nursi duties and other work to be assigned to auxilia personnel. It is the feeling of hospital administrato and directors of nursing schools that the situati has begun to show improvement and that it is easi now to obtain nurses in various grades than it w

one year ago. The Hospital Career Campaign for the recruitment of student nurses for 1948 gives promise of an increased student nurse enrollment.

2. Under the second heading which relates to the proposed training of all grades of nurses in the future, your committee is prepared to make definite and concrete recommendations. We have investigated and studied carefully the question of bedside nursing and the required training for this grade of nurse. We recommend two main classes of nurses: (A) Professional nurses; (B) *Trained* practical nurses.

(A) PROFESSIONAL NURSE

This group is to be subdivided into (a) nurse educators; (b) clinical nurses.

(a) Nurse educators are to be those with collegiate training and others who have shown an aptitude for teaching, administration and supervisory positions. These are to fill the positions of directors of nursing schools, teachers, department and clinical supervisors, public health nurses, etc. The training for these nurses should be collegiate training before entering the nursing field or combined collegiate and nursing training.

(b) The clinical nurse is to be comparable to the present day general duty or private duty nurse. Selected clinical nurses with an aptitude and ability for teaching may well be considered for some of the subordinate teaching positions. We recognize that there are many duties to be assigned to this grade of nurse which could not be filled by the *trained* practical nurse. We recommend that the course of training for the clinical nurse be reduced to two years.

(B) THE TRAINED PRACTICAL NURSE

Your committee has underscored the word *trained*. Unfortunately it seems to the committee, the term "practical nurse" bears the implication of no training. However, the term has already been written into the statutes of several states and a change of the name would be difficult. At the same time the committee feels that the name is not of major significance, but does feel, however, that it is very important that uniform standards of training and duties be established across the country. For this group your committee recommends one year of training made up of three months theoretical and nine months practical training. This can be accomplished completely, in a hospital, or the three months theoretical training may be taken under a department of education and the nine months training in an acceptable hospital. Your committee feels that this group of *trained* practical nurses, under proper supervision of professional nurses and medical staff, will be able to do much of the routine bedside nursing now being done by professional nurses, but that the more delicate and intricate duties must be left to the professional nurse. We believe that sufficient bedside nursing care can be obtained economically and efficiently if the professional nursing staff is augmented by *trained* practical nurses. Provision should be made, and credits allowed, in selected cases, toward training for advancement from the grade of *trained* practical nurse to the grade of clinical nurse.

3. The last or economic problem presents certain features which should be corrected. Your committee urges that steps be taken to provide social security and retirement plans for all nurses. This is advised from the business and moral viewpoints. We also recommend that hospitals adopt a definite personnel policy, for all institutional nurses, with a view toward making salaries, hours, sick leave, and vacations comparable to other fields of endeavor, for women, with equivalent education and training.

The committee recommends that the cost of essential special nursing care, to the patient, be covered by prepayment nursing plans or be tied into prepayment hospital and medical plans, if practicable.

The committee feels that the nurses innocently erred in their action in Atlantic City in 1946 when they voted to have their state organizations act as bargaining agents for them. They are members of a noble profession. They do not need bargaining agents. The term bargaining agent carries with it the implication to strike even though it is true that they have never gone on strike. Medical men, nurses, and other hospital employees have not the right to strike anywhere, any time. They are dealing with that most priceless possession—life itself. It is hoped that the nurses will correct this in the near future.

A permanent Conference Committee made up of representatives of the American Nurses Association and other nurse organizations, the American Hospital Association and the American Medical Association has been formed. The duties of this committee will be to study the problems common to all. Nursing problems are the most urgent and import-

ant at present. This committee might well be used to adjust any differences that any of the groups might have.

The committee wishes to thank Dr. E. L. Bortz, the President of the American Medical Association, Dr. Elmer Henderson and the Board of Trustees, Dr. Morris Fishbein, the editor of the *Journal*, and the representatives of the American Hospital Association for their cooperation and aid in this study. The representatives of the various nurses organizations have been very helpful to the committee. They are very anxious to have this whole nursing problem solved and have cooperated fully. The committee expresses its gratitude for their aid.

And so we end, at least for the present, the study of the nursing problem and summarize it as follows:

1. It is estimated that about 400,000 nurses will be required to care for the American people in 1949. The committee feels that this can be accomplished.

2. Labor Department statistics indicate that about 550,000 nurses will be needed in 1960. To accomplish this about 50,000 nurses must be graduated each year between 1951 and 1960. This can be accomplished by the generous cooperation of all concerned.

3. The committee has proposed measures for th relief of the present situation and feels that muc has been accomplished.

4. The committee recommends that changes b made in the present method of training nurses; th in the future nurses be made up of two main grou —the professional nurse and the *trained* practic nurse. The requirements, duties, and courses o training of both main groups have been outline

5. The economic situation has been reviewed an methods of correction suggested.

6. A permanent Conference Committee has bee formed, made up of representatives of the America Nurses Association, the American Hospital Asso ciation and the American Medical Association.

7. The committee believes that this permanen Conference Committee will be the organization t implement your committee's recommendations an the recommendations that come from other inter ested groups.

Respectfully submitted:

Warren Draper, M.D.,
Howard Gray, M.D.,
Leland McKittrick, M.D.,
Donald Smelzer, M.D.,
T. P. Murdock, M.D., *Chairma*

TWENTY-THIRD CLINICAL CONGRESS
of the
CONNECTICUT STATE MEDICAL SOCIETY
and the
YALE UNIVERSITY SCHOOL OF MEDICINE

September 14, 15, 16, 1948

The morning presentations will be given in the auditorium of the Yale Law School and the afternoon panel discussions and symposia will be held in the amphitheaters of the New Haven Hospital and the School of Medicine.

TUESDAY, SEPTEMBER 14

9:00 Headache Mechanisms
Harold G. Wolff, *New York*

9:30 The Group Management of Ulcerative Colitis
Chester M. Jones, *Boston*

11:10 To be Announced

11:40 Lymphoma
Lloyd F. Craver, *New York*

12:10 Discussion Period

2:00 Panel Discussion on Dizzy Spells
Paul I. Yakovlev and others

Panel Discussion to be Announced

Panel Discussion to be Announced

3:00 Panel Discussion on Brain Tumors
Frederick C. Redlich and others

The Pathogenesis of Liver Disease
Speaker to be announced

The Relief of Intractable Pain in Visceral Disease
James C. White, *Boston*

WEDNESDAY, SEPTEMBER 15

10:00 Practical Implications of the Rh Factor in Clinical Medicine
Louis Diamond, *Boston*

10:30 The Heart in Pregnancy
Burton E. Hamilton, *Boston*

11:10 Recent Advances in Heart Disease
Charles C. Wolferth, *Philadelphia*

11:40 Current Trends in Diabetes
Elliott P. Joslin, *Boston*

12:10 Discussion Period

2:00 Pediatric Subject to be Announced

Panel Discussion on Diabetes
Barnett Greenhouse, Elliott P. Joslin and others

Disorders of Menstruation
John Rock, *Boston*

3:00 Industrial Dermatoses
Leon Goldman, *Cincinnati*

Diet in Hypertension
George A. Perera, *New York*

Infertility
Charles M. McLane, *New York*

THURSDAY, SEPTEMBER 16

10:00 Surgery of the Hand
Michael L. Mason, *Chicago*

10:30 Physical Rehabilitation in General Practice
Howard A. Rusk, *New York*

11:10 Intrinsic Asthma
Francis M. Rackemann, *Boston*

11:40 Arteriosclerosis Obliterans
Leland S. McKittrick, *Boston*

12:10 Discussion Period

2:00 Panel Discussion on Urinary Tract Infections

Panel Discussion on Allergy
Francis M. Rackemann and others

Panel Discussion on Hand Surgery
Michael L. Mason and others

3:00 Panel Discussion on Deafness

The Management of Psychosomatic Disease
Henry Fox, *Boston*

Panel Discussion on Peripheral Vascular Disease
Leland S. McKittrick and others

Demonstration of Prosthetics

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

The Problem of Rural Doctors

One of the greatest problems facing medicine today is the lack of qualified physicians in country districts. According to Dean W. C. Davison* of the Duke University School of Medicine, there are at least five factors responsible for this condition: 1. The medical schools; 2. Too few country medical students; 3. The teaching hospitals; 4. The dearth of rural hospitals; 5. The present erroneous conception of country practice.

Dean Davison points out that clinical branches are taught in medical schools by specialists and the result is an unconscious emphasis on specialism. He recommends that there should be a greater use of general practitioners as teachers and that courses in family practice should be given for third and fourth year students. The curriculum must be molded to fit the requirements of general practice. It is obvious that such basic training is equally valuable for the student who is aiming at specialization.

Medical school graduates tend to return to the environment from which they came. More qualified medical students from country areas are needed. A greater search should be made for keen students to attend medical schools from rural areas.

The large hospitals, especially teaching hospitals, are responsible because most of them have "straight" services which lead to residencies in special fields. What is needed is more two year "mixed" internships designed to train graduates for general practice. Teaching hospitals and medical schools also must make general practice more interesting by providing more postgraduate opportunities for the family doctor in their vicinity.

The unavailability of hospitals in which rural physicians can practice is another factor to be considered. If the Hill-Burton bill is given sufficient funds, hospitals and health centers can be built in certain needed areas. Hospital and other insurance plans for those who are self-supporting, and county, state, or federal funds for the indigent will be helpful.

The present conception of country practice, which is largely erroneous, also shows responsibility in the problem. In many rural areas, owing to improvement in farming conditions and lack of competition, the incomes of the better qualified physicians are better than those of physicians in rural areas, and living costs are considerably less. Office practice is also greatly increased. In North Carolina, 65 per cent of a general practitioner's practice is now in his office.

Dr. Davison recommends that more family doctors should form partnerships and practice in groups, that general practitioners should be appointed to the staffs of all hospitals, both private and government, and that a general practice board should be formed.

*Davison, W. C.: Rural General Practice in Groups. Journal of the Assoc. Amer. Med. Coll. 23, 180, 1948.

An "Index of Curative Skill"

"To become an able and successful man in any profession, three things are necessary, nature, study, and practice."

Henry Ward Beecher

No doubt many men, some obscure, others ultimately prominent, have undertaken the study of medicine and have abandoned it because they became more vitally interested in some other pursuit. Very often such men have wandered into allied fields of endeavor. Thomas Henry Huxley, the biologist, comes to mind as an example, for he as a medical student of nineteen described the layer of cells about the root-sheath of the hair follicle which has since borne his name. Medicine must be a fascinating study even to those who abandon it, and we recently picked up an old book which illustrates what a profound impression it may leave on the mind of a contemplative observer: "Memories of My Life" by Francis Galton. The author, the grandson of Dr. Erasmus Darwin and the nephew of Charles Darwin, might be described as "the father of Eugenics," for after abandoning medicine one of his outstanding interests was heredity. As his book shows, his medical experiences made a profound impression on his mind, and in describing his hospital life he makes, among others, the following statement: "the opinions held by the students about the several physicians and surgeons were curiously guided by a mixture of loyalty and irreverance. There was no doubt of the fact that M., one of the doctors who never professed or had a claim to scientific acquirements, got his patients out of hospital more quickly than any of his colleagues." "It is to be wished that some 'index of curative skill' could be awarded to doctors, based on their respective hospital successes." "If it could be compiled truthfully, it would be an excellent guide to those who wanted a doctor but were doubtful whom to consult."

The idea that Galton suggests is interesting and stimulating, but one wonders how practical it is. We may note in the first place that Galton entered the Birmingham General Hospital as a house pupil in 1838, a period when the era of bleeding, purging and puking, while not perhaps in its heyday, was still in vogue. As for the successful doctor M., Galton records that his treatment "consisted of a strong purgative followed by a low diet, and a subsequent feeding up as soon as all fever had gone." This is not very different from the modern treatment of infections, minus specific therapy, for i the memory of many of us the "preliminary purge was still, and no doubt is still, in use by man physicians.

So M. earned his index of curative skill, just a did the homeopaths, by demonstrating again wha old Ambroise Paré had in mind when he recorde after so many of his case reports, "and I dresse him and God cured him." In brief, M., by leavin his well-purged patients to the tender mercies o Dame Nature and feeding them up during con valescence was more successful than his colleague many of whom were doubtless still wedded to th methods of Dr. Sangrado. He proved that the heal ing powers of nature, which the old-timers de scribed as the "Vis medicatrix naturae," were in finitely superior to the drastic therapy of his day

As to the feasability of ranking modern physician in such an index as Galton proposed, we have ou doubts. There have been, since Galton's time, no only immense advances in medical knowledge, bu great progress in the classifying of competent doc tors. Not that all doctors are, even now, equally successful in curing their patients. However, ther are so many factors in therapeutic efficiency, in cluding luck, good judgment, personality, knowl edge, and skill, that we doubt that an attempt t fairly classify physicians according to their curativ results would be very practical. We suspect tha the matter of their efficiency had better be left i the hands of the Medical Schools, the State an Specialist Boards, the judgment of their peers and above all, the good sense of the public, who in spit of their many vagaries, still tend, in the long run to reach somewhere near the truth in estimating th capacity of physicians.

G. B.

Residency Training for General Practice

The University of Michigan Medical School ha established in its University Hospital a new type o residency, designed especially for the extended graduate training of doctors for the general practic of medicine.

The training program as now constituted provide an internship of twelve months, to be followed by a year of residency, and an optional third year. The services through which the intern and general resident rotate are particularly chosen to provide a

aximum amount of training in the various fields f medicine with which the general practitioner will e concerned.

The general residencies are integrated with the sidencies for specialty training, and like them, are part of a decentralized program, which rotates sidents from the services at the University Hos- ital to any one of a number of affiliated hospitals. he general residents, under the present plan, spend x months of each year in the University Hospital d six months in an affiliated hospital.

The curriculum for the first two years includes vo months on the medical wards of the University Iospital, and two months each in pediatrics, and bstetrics and gynecology in the same hospital. The utpatient service of the University provides two onths each in dermatology, surgery and neuro- sychiatry. The services in the affiliated hospitals re divided into medical and surgical. The resident ends three months of each year of training on one f these services.

The affiliated hospitals have organized their staffs conduct resident training by conducting teaching ard rounds five days each week. A clinical-patho- gical conference is held once a week for nine onths of the year, and an x-ray conference is onducted on the same schedule. In addition there a clinical conference weekly for the study of iagnostic and therapeutic measures.

A review of the above program suggests that the resent-day popularity of specialty training may e due to the fact that, until recently, such training as the only medium of postgraduate instruction. n the absence of extended preparatory courses for eneral practitioners there has been no alternative or a young doctor, who desired more training after standard rotating internship, but to enter a medical r surgical specialty.

It seems reasonable to assume that because of the remendous growth of medical knowledge, many nterns may be hesitating to enter general practice ecause of a feeling of insufficient preparation, and herefore seek additional training and a sense of ompetence in the only manner which is now gen- rally available—specialty training.

It has often been said, and rightfully so, that a ell trained general practitioner exceeds all the pecialties in the breadth and detail of his knowledge nd training, and that general practice is the most xacting of all the branches of medicine. Aside from he possibility that general residencies may induce more graduates to enter the general practice of medicine—even if such residencies furnish training only to those who would enter general practice any- way—we believe that programs similar to the one described above will be eminently worthwhile.

From the Journal of the Indiana State Medical Association

Dr. Hawley Speaks Out

In a forceful and challenging speech given re- cently in Chicago before the 4th Annual Confer- ence of Presidents and other officers of State Medical Associations Dr. Paul R. Hawley, chief executive officer of Blue Cross and Blue Shield Commissions, warned that government medicine is coming soon if "organized medicine (pursues) the same course that it has pursued for the past ten years." This can be averted, according to Dr. Hawley, only through greater expansion of voluntary prepayment medical care plans to cover the greatest number of people by offering contracts to fit all incomes. This means the offering of contracts of various types with varying premiums and varying schedules. In order to further such plans Dr. Hawley recommended the establishment of a National Service Agency to underwrite—but not control—local medical care plans. Other quotes from Dr. Hawley's forthright remarks:

"Our national leaders seem to be purposefully blind to the social changes that are taking place." . . . "Too many physicians regard medical care as their exclusive prerogative." . . . "My heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physi- cians who had rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest." . . . "If we get socialized medicine in this coun- try it will be organized medicine that has brought this curse upon us." . . . "If the medical pro- fession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary nonprofit prepayment plans, we are going to have compulsory government health insurance in this country within three years."

Political Partisanship

In large measure our political life is controlled by political parties and a good part of the voter's fran- chise is forfeited if he is not enrolled in a political

party. This is true in all states except those which have "open" primaries, for he has no voice in the all important selection of candidates for public office. In many instances the selection of such candidates is tantamount to election. Too often the "independent" voter condemns political organizations and politicians thoughtlessly, not realizing that we will only get competent people to run for public office when political organizations are controlled by competent people. Candidates are almost invariably nominated by the party system. Moreover, the condemnation of politicians per se is highly dangerous to our whole democratic system, and it alone has often prevented high minded and high principled men and women from entering politics. As a matter of fact, such cynicism is largely unwarranted, for most of the real work in American political life is done by competent men and women. Many people have a false sense of pride in being "independent" voters. As a group whose interest lies in social legislation as it applies to medicine, our profession must realize that for the actual enactment of desired legislation political party support is required. Party leadership is chiefly interested in party support no matter how much candidates for public office may woo the so-called independent vote. We have a tremendous stake in legislative matters pertaining to social medical relationship and we can only make our voice really effective by working through party organizations. To do this means that each of us should be enrolled in a political party, caucus, or primary—a member of a party.

Report on the Nursing Problem

The Report of the AMA Committee to Study the Nursing Problem, which appears elsewhere, deserves thoughtful consideration because of its intimate concern to medical practice. The role of the physician as a key figure in the recruitment of student nurses is an important one. The recommendation of the Committee to give greater recognition and responsibility to the *trained* practical nurse is a practical solution of the problem of bedside nursing which most physicians will welcome. The recommendation, if adopted, that in selected cases such nurses can with further training attain the grade of clinical nurse, should prove an incentive which will aid in attracting young women to th field. The Permanent Conference Committee me tioned in the Report will do much to further goo relationships between nurses, physicians, hospit administrators, and others who are intimately co cerned with nursing care. As might be expecte from the calibre of the men who served on th committee, a splendid job has been done. We co gratulate Dr. Murdock and his associates!

What Connecticut Does

The Indiana State Medical Association has ju completed an inquiry among state medical societi to find out what kind of service the societies rend their members. Forty-seven states answered th inquiry.

Indiana found out that of the forty-seven state sixteen had health and accident group coverag available for its members. Connecticut was one o the sixteen.

Eighteen of the forty-seven societies provid group professional liability insurance. Connecticu was one of the eighteen.

Legal counsel for members sued for malpractic is provided by eighteen of the forty-seven societie Connecticut was one of the eighteen.

The 1948 Clinical Congress

A study of the preliminary program for the 194 Connecticut Clinical Congress shows that the Pro gram Committee under the guidance of Dr. Hug L. Dwyer has done a fine job in arranging to brin to our members an outstanding program in clinica medicine. Its excellence is no doubt a reflection o the real effort that is being made by our Society an the School of Medicine in cooperative effort t develop opportunities in postgraduate teaching Now in its 24th year, the Connecticut Clinical Con gress is recognized as a successful pioneering enter prise in such cooperation. This success may b measured in two ways: by the increased interest o those who attend from year to year, and by th calibre of the speakers which are attracted to par ticipate. In this latter criterion, the 1948 progran speaks for itself. It will be difficult to stay away.

PROGRESS IN CLINICAL MEDICINE

OBESITY

Wilson Fitch Smith, m.d., *Hartford*

Obesity is an unnecessary hazard in life. For a long time it has been known that overweight a threat to longevity. The life insurance com- anies "rate up" or refuse to insure an obese candi- ate. The seriousness of the extra pound of flesh is riking when it is shown that for each pound of verweight in the 45 to 55 year age group there a 1 per cent increase in the expected death rate.[1] he mortality of the obese population is even as reat as in those who suffer with organic heart isease.[2] Not only does obesity favor development f heart disease, pulmonary disease, renal disease id diabetes, but it also is a danger on its own. The bese person is more prone to serious accident, to aricose veins, to arthritis in the weight bearing oints and to gall bladder disease.

In contrast to the elaborate and expensive cam- aigns that are being waged against cancer and eart disease, tuberculosis and infantile paralysis, besity is a serious health threat that could be less- ned inexpensively and with little difficulty. It can e spotted almost as far as a person can be seen. Not only does it require no costly nor complex reatment, but it is truly preventable. Once obesity established, however, the treatment is long and edious for the patient and not all of its ill effects are eversible. Therefore, to prevent the insidious de- elopment of overweight, there should be more ducation of the public and more zeal on the hysician's part.

ATHOGENESIS

In the past, various mechanisms have been pro- osed as causing obesity. They have had their fol- owers and their vogues, but more recent studies ith better controls have succeeded in disproving ost of them. There remains but one statement: *obesity results only from eating more than is equired to meet the energy requirements of the ody.*"[1,7] Thus endocrine dysfunctions, disturb- nces in metabolism, variation in absorption of food, pophilia (constitutional abnormality of adipose tissue), luxuskonsumption (failure of acceleration of metabolism after eating), water retention and genetic factors can all be dismissed except in a few rare and isolated cases. Examples of these exceptions include the hereditary Laurence-Moon-Biedl obesity in the mentally deficient child with polydactyly, retinitis pigmentosa and hypogenitalism and also the characteristic obesity of Cushing's syndrome secondary to tumors of the adrenal cortex.

If overeating is the chief factor in overweight, increase in appetite is the primary consideration. *Hyperorexia* may therefore be a more accurate term than obesity.[2] There are several types of abnormal appetites which cause obesity, and it is well to distinguish them at the start, for the prognosis varies considerably. Efforts at treating certain overweight cases may be entirely wasted, while other cases may respond readily.

One variety of abnormal appetite seems to depend on habit. There are two kinds of habitual influences on appetite. The first is the result of longstanding factors of environment and training. Some families are notoriously good eaters, being famous for their hearty meals and big appetites. The fact that they all tend to be overweight is taken pretty much for granted. In other households parental efforts and urgings are all focused on the importance of eating, so that as the child grows up he may be conditioned to eat too much. Furthermore, an occupational tendency is found in cooks, etc., who are always tasting and nibbling their wares. Finally, the old college athlete is a familiar figure. His habit of eating huge meals continued long after the violent exercise requiring them ceased. Now as he sits all day at his desk, his chair gets pushed further and further back by his influential paunch. All of these examples of overweight due to habitual large appetite respond well to therapy which consists chiefly in reeducation.

In the second group of habitually increased appetites, obesity dates back to a specific illness or

operation. Many women date their overweight to pregnancy. It seems that habit plays a contributing role by maintaining a good appetite when a body at rest is needing less fuel. Convalescent diets are often highly nutritious and start a habit pattern that is continued long after its need is over. Infection or trauma may in addition cause disturbance in the function of the hypothalamus where the appetite center is supposed to reside.[3] Whatever the cause, these cases of abnormal appetite usually respond well to reeducation.

Excessive eating is often an expression of disturbed emotional balance and is usually a substitute for some lack in the pattern of living. It is believed that the autonomic control of primitive emotions and behavior located in the hypothalamus includes appetite control. This function may be interrupted by psychologic as well as organic interference, so that the customary dietary intake may fail to produce the normal feelings of satisfaction and repletion.

Two degrees of emotional interference must be recognized. One is the deep seated emotional disturbance that dates back into early childhood influences and produces a condition that might be called "hyperorexia nervosa"—akin to anorexia nervosa—which also requires detailed psychiatric treatment. It is well to recognize such severely psychoneurotic cases early and have proper psychotherapy started soon, for otherwise efforts at weight reduction will be met by failure. A less profound psychosomatic disturbance is caused by temporary emotional tension arising from fear, worry, dissatisfaction or resentment with resulting compensation in overeating. Such cases can often be cared for by an understanding physician without formal psychotherapy. In these cases, of course, there may be an indirect glandular etiology in so far as emotional tension is increased at such times as puberty, pregnancy, premenstrually and at the climacteric.[3] It must be remembered, furthermore, that the disability of obesity in itself may provide a wanted retreat from the unpleasant demands of life. This secondary gain may not be recognized consciously by the patient and may result in an opposition of forces between the overt desire to reduce and the hidden resistance to treatment.[4]

TREATMENT

In the treatment of obesity it is of paramount importance to keep in mind the reason for weight reduction, namely, the prevention of future organ disease with increase in mortality rates. This mea that any short term program that results in a rapi but temporary weight loss is a waste of the patient efforts and of the physician's time. The goal shou be a weight reduction that is maintained throug future years. No treatment of obesity should b considered successful that is followed by a retu of excess weight after the ideal level is reached. T achieve this end it is necessary to go further tha just diet and drugs. The patient should be brough to recognize the reason for the increased appeti and through proper mental hygiene should acqui normal eating habits.

Every overweight patient should have a comple physical examination before starting treatment. Th is to evaluate the degree of damage, if any, alread exacted by the strains of excess weight. It is also t search for any underlying organic conditions tha could contribute to emotional instability, such a anemia or an obvious focus of infection. A dete mination of hemoglobin and a urinalysis should b routine, while a basal metabolic rate is of interes though not reliable in the excessively obese case.

An attempt should be made to bring to light th possible emotional factors responsible for insecurit or irritability which is causing the compulsive appe tite. Fear of economic insecurity, frustration fro undesired social position, shame for inadequat capabilities and shyness are often compensated fo by overeating.[5] A careful personal history is nece sary, with the patient discussing the family back ground, the childhood influences and experience the personal reaction to the various physiologi stages of development, the emotional experiences o schooling, occupation and marriage. The patien should be encouraged to talk of his own feelin and reactions to his love affairs, religious exp riences, ambitions, etc., as he passed through adole cence into adult life. The doctor's questionin should be kept to the minimum necessary to kee the conversation progressing so that voluntary an unbiased statements may be obtained. And yet a complete a review as possible should be made o all the elements that might enter into an emotion basis for hyperorexia. This is a time consumin the reasons for obesity. Unless the fundament procedure, but by this alone can insight be gaine into the reasons for obesity. Unless the fundament nature of the disturbance is understood, therap is doomed to failure.[6]

In accomplishing the gradual reduction of weight, te submaintenance diet is important. Rather than rmit the patient to restrict caloric intake indis- iminately, a detailed routine should be outlined that a diet is followed adequate in all other re- ects than calories. Since this routine must be dured for months and even years, it is imperative see that adequate protein is eaten. One gram per ogram of body weight is a good average. Enough rbohydrate must be included to prevent wasting protein and to insure against acidosis. No stand- d diet can be used for all patients, but rather an justment must be made for personal requirements d economic limitations. An overweight truck iver, for instance, would need a vastly different et than a plump society matron. A diet calculated cause the loss of a pound or two a week is ideal. fter a trial period it may have to be adjusted better suit the patient's needs. Emphasis should be on an lequate daily diet which is slightly submainten- ıce in caloric value and which can be tolerated definitely, rather than on any starvation routine hich could be endured safely for only a brief time. hus a return to normal food habits and appetite reached and a pattern is established which can be llowed with slight modification for the rest of fe.

The diet should include some means of substitu- on of food categories, so that exceptions may be ıade to allow for the variations imposed by social vents, etc. For instance, bread substitutes may be sted wherein most of the starchy foods are given ı equivalent values. By consulting this list and ıving up the day's budget of bread, a special spree an be enjoyed, even an alcoholic drink. At other imes a cup of skimmed milk may be swapped for small serving of ice cream. In this way the obese atient can continue to live a normal, comfortable fe while still adhering to a weight reducing regi- nen.

It is usually advisable to amplify the low caloric liet with vitamins, especially the fat soluble ones. The easiest way is to add a polyvitamin capsule ontaining the daily minimum requirements. Ferrous ulfate or a similar iron preparation should also be ncluded with the routine diet.

Additional factors often considered in weight reducing programs can be dismissed with a brief word. *Exercise* is usually a futile method of taking off weight, for it requires a lot of exercise to work off a pound of fat. Furthermore, vigorous exercise is usually contraindicated in obese patients. Actually it takes far less exercise to remove that fat in advance from the daily menu than it does later on from the hips. In addition, exercise whets the appetite and thus defeats its purpose. It is true that certain exercises are good to tighten up flabby muscles and have a definite part in the restitution of an esthetic silhouette. *Drugs that increase metabolism*, particularly thyroid extract, increase appetite and also increase the burden on an already overtaxed cardiovascular system. Small doses of thyroid extract occasionally may be needed after the first successful steps of reduction have taken place and a plateau is reached in the weight loss curve, since this is partially caused by a lowering of the metabolic rate on a low caloric diet. *Drugs that depress the appetite*, as amphetamine,[6] have had a popularity in many of the "quick cures," but their effect is transient. Follow-up studies show that the weight loss produced by them is also short lived. They may help temporarily with hard-to-control appetites, but they depress the appetite for essential food as well as for the fattening ones. The main difficulty in using drugs as adjuncts to diet is that the patient often assumes that the drug is the important factor in the weight loss and consequently finds it easy to lapse from the diet. The patient should understand from the beginning that the cause of obesity is eating more fuel than is burned.

CONCLUSIONS

When long term results are used to determine success, it is common experience that treatment of obesity by calculated diets alone results in as high as 80 per cent failures.[7,8] The use of psychotherapy—chiefly reassurance and interpretation—however, has been highly successful even without prescribing calculated diets. Nicholson at Duke University[8] had four groups of obese patients under different treatment schedules. Diet alone was successful in only 25 per cent. There were no permanent successes with either amphetamine or thyroid extract as the sole treatment. While psychotherapy without any other treatment succeeded in 70 per cent of all cases.

It would seem, in conclusion, that the ideal therapy for overweight should be a combination of psychotherapy and calculated diet. Thus, with the gradual reduction of the present overweight population and the prevention of future obesity through

education, much can be done to decrease disability and death from degenerative diseases predisposed to by obesity.

BIBLIOGRAPHY

1. Gastineau, C. F., and Rynearson, E. H.: Annals of Internal Medicine 27, 883 (1947) (Obesity).

2. Proger, Samuel: Lecture on Obesity, Hartford Hospital, November 22, 1947.

3. Freed, S. C.: J. A. M. A. 133, 369 (1947) (Psychic Factors in Development and Treatment of Obesity).

4. Hart, A. D.: J. A. M. A. 136, 147 (1948) (Psychosomat Diagnosis).

5. Waife, S. O.: Am. Pract. 2, 47 (1947) (Pathogenesis Obesity).

6. Rennie, T. A. C.: Diseases of Nervous System 1, 23 (1940) (Obesity as a Manifestation of Personality Disturl ance).

7. Danowski, T. S., and Winkler, A. W.: Am. J. Med. Se 208, 622 (1944) (Obesity as a Clinical Problem).

8. Nicholson, W. M.: Am. J. Med. Sci. 211, 443 (1946 (Emotional Factors in Obesity).

General Practitioners Plan Annual Meeting

Physicians who desire membership in the Connecticut Chapter of the American Academy of General Practice must apply by September 3 in order to qualify for voting at the Chapter's first annual meeting, according to Dr. Michael Palmieri, New Haven, acting secretary.

The annual meeting will be held as a feature of the Clinical Congress scheduled for September 14, 15, and 16, in New Haven. Application blanks were recently mailed to all Connecticut physicians.

Dr. Palmieri has announced that the Chapter is planning its meeting for Wednesday, September 15, and that the principal matters of business will include election of state officers and organization of county groups. A luncheon is also being planned.

Other temporary officers of the Connecticut Chapter are Dr. Julius H. Grower, Middletown, chairman, and Dr. Walter V. Corey, Hamden, treasurer. To be eligible for membership, physicians must be engaged in general medical practice, and must have completed at least three years of such practice. Special consideration is given in cases of military service. Applicants must also have had at least one year of rotating internship at an approved hospital, or the equivalent in postgraduate training. Membership in the American Medical Association is a requirement of membership in the Academy.

Tumor Study Committee Appoints Dr. Oughterson

The Tumor Study Committee of the State Medical Society has recently appointed Dr. Ashley W. Oughterson of New Haven as coordinator of detail studies of the incidence, treatment and survival periods for cancer of the breast, uterus and colon. Tumor clinics throughout the state have been asked to nominate physicians who are interested in aiding these studies. Dr. Oughterson will form teams from among these men to study the different phases of this subject and the results of their work will eventually be reported to the Tumor Study Committee. This is a long range project, the success of which will depend in a great measure upon the cooperation of individual physicians and hospitals throughout the state. If there are any doctors, particularly those associated with tumor clinics, who are interested in participating in this activity, they may write to Dr. Oughterson at 38 Trumbull Street, New Haven. The cancer records collected in the State Department of Health under the supervision of Dr. Griswold and the recent analysis of this material by Dr. Griswold and Miss Macdonald will provide the basis for the beginning of this study.

Panel of Specialists to Visit Cancer Clinics

Through a plan set up by the Association of Tumor Clinics and the Medical Advisory Committee of the Society, a panel of cancer specialists will carry their skill and experience to tumor clinics throughout the State. The clinics will specify the specialists they wish to have make the visit.

The services of the consultant will be at the disposal of the clinic for help with particular diagnosis and treatment problems, or for discussion of general principles in the specialist's field. The following constitute the panel of consultants: Surgeons: Samuel C. Harvey, Edward J. Ottenheimer, Ashley W. Oughterson, Max Taffel, John O. Vieta and N. William Wawro. Gynecologists: Carl Johnson, Louis F. Middlebrook and Arthur Morse. Urologists: Phillip Cornwall and Chris Neuswanger. Radiologists: Gilbert Heublein, Arnold H. Janzen, Ralph Ogden, Berkley Parmelee and Hugh Wilson.

THE PRESIDENT'S PAGE

The House of Delegates at the last Annual Meeting authorized an entirely new committee, as set forth in the May issue of this Journal, to study a pre-payment medical plan quite different in its composition from those previously set up. It has been instructed by the House of Delegates to prepare in detail a non profit organization along the lines of the Blue Shield in Massachusetts and the United Medical Service in New York City which do not differ materially in their basic arrangements and provide experience which will be of the greatest assistance in the work of the Committee.

It should be emphasized that this Committee which is now in action is composed of one representative from each county society as appointed by it and therefore derives its authority directly from the organization most intimately related to the individual practitioner. It reports directly to the House of Delegates for unified action at the state level, and for this purpose it is empowered to call a special meeting at any time it sees fit. If this proposed organization is approved, it will continue as representative of the State Society in its introduction and subsequent administration.

It is to be presumed that the members of this Committee will in its deliberations become better informed concerning the problems involved in the field of prepaid medical service than are many of the members of the constituent societies. This, however, does not relieve the individual physician of his responsibility for acquiring sufficient understanding so that he may base whatever position he may take, whether in favor or in opposition, upon factual information rather than in accord with innate prejudices. This is doubly important in that the successful operation, whatever the program adopted may be, is dependent in large part upon his understanding of it and a willingness to undertake the responsibilities incurred. Moreover, whatever form it may take at the start, there may well be adjustments to meet circumstances either not completely understood at the moment of inception or appearing with the passage of time. This, likewise, will require the intelligent and informed consideration of the participating physicians expressed through their representatives in the Committee.

Samuel C. Harvey

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PREPAID MEDICAL SERVICE

The new Committee on Prepaid Medical Service authorized by a resolution of the House of Delegates at its Annual Meeting on April 27 was called together for organization by Dr. Harvey, President of the Society, on June 29. Thomas J. Danaher, Torrington, was elected Chairman of the Committee, and James R. Cullen, Hartford, Secretary. Membership of the Committee consists of Fairfield, Joseph H. Howard, Bridgeport; Hartford, James R. Cullen, Hartford; Litchfield, Thomas J. Danaher, Torrington; Middlesex, Norman E. Gissler, Middletown; New Haven, Walter I. Russell, New Haven; New London, Henry A. Archambault, Taftville; Windham, William Mac Shepard, Putnam. The Tolland County Association has not named a member to the Committee. Attending the meeting on June 29 were Drs. Danaher, Cullen, Russell, Archambault, Howard. Absent: Drs. Gissler, Shepard.

Mr. Frank Smith, Director of the Associated Medical Care Plans, Chicago, was the guest of the Committee and discussed at length the organization and operation of non profit medical care plans. The Committee voted to consider tentatively the extension of a service plan at an income level that would include at least fifty per cent of the wage earners in the state and the staff in the Executive Secretary's office was asked to accumulate data on this subject from the State Department of Labor and other sources.

Committee to Coordinate County Association By-Laws

A. Lewis Shure, New Haven; Frank Couch, Cromwell; and Thacher Worthen, Hartford; have been appointed a Committee to Study the By-Laws of the County Associations and endeavor to bring them into agreement so that there will not be inconsistencies between the county associations. This action was recommended by the Committee to Study the Organizations and Objectives of the Society and authorized by the House of Delegates at its Annual Meeting.

Clinical Congress Committee

The Council accepted with regret the resignation of Francis G. Blake as Chairman of the Committee on Clinical Congress and Herbert Thoms was appointed to succeed Dr. Blake to direct the program of the 1948 Congress. After 1948, arrangements for the Congress will be under the new Committee on Postgraduate Education, which was authorized by an amendment to the By-Laws by the House of Delegates on April 27.

Program Committee

Max Taffel, of the Department of Surgery of the Yale Medical School, has been appointed a member of the Program Committee to succeed Harris B. Shumacker, Jr., who was unable to accept election. Dr. Shumacker is moving to Indiana to become Professor of Surgery at the University of Indiana.

State and Community Program for Children and Youth

The State Commissioner of Health has asked the Society to name a representative to serve with a state planning group for promoting state and community programs of action for children and youth. J. Harold Root of Waterbury has been designated as the Society's representative in this activity.

State Blood Bank

Meetings for the direction of the State Blood Bank have been held by the Society's Blood Bank Committee, representatives of the American Red Cross, Yale School of Medicine and others. Progress

s being made and it appears certain that a state blood bank organized by the Red Cross and under the professional supervision of the State Medical Society will become a fact before the year's end.

Dr. Lindskog New Professor of Surgery



GUSTAF E. LINDSKOG, M.D.

Dr. Gustaf E. Lindskog has been appointed William H. Carmalt professor of surgery and head of the Department of Surgery, Yale University School of Medicine.

The professorship was formerly held by Dr. Samuel C. Harvey, now Yale's first professor of surgery in oncology, and president of the State Medical Society.

An associate surgeon on the staff of the Grace-New Haven Community Hospital, Dr. Lindskog is a member of the American College of Surgeons, the American Surgical Association, the New England Surgical Society, the Society of University Surgeons, and the American Association for Thoracic Surgery. He is a member of the State Medical Society and local and national medical organizations.

Dr. Lindskog received his medical degree at Harvard Medical School in 1928, is a graduate of Massachusetts State College, and has practiced medicine in Connecticut since 1932.

Dr. F. N. Otis Honored Guest at Testimonial

More than 40 doctors of Meriden, Wallingford, and Southington gathered on June 16 in Waverly Inn, Cheshire, to join with the Meriden Medical Society in paying honors to Dr. Fessenden N. Otis, pioneer local roentgenologist, who retired on June 30 from the Meriden Hospital staff to devote his entire time to his private practice.

Numerous speakers from among the general practioners and specialists praised Dr. Otis for his generous counsel and advice on difficult cases over the many years he was head of the radiology department at the local hospital. The doctors were unanimous in giving him complete credit for building the service at the hospital to its present high standard of efficiency.

Louis A. Pierson, chairman of the committee on arrangements, introduced by Edward W. Foster, president of the Meriden Medical Society, said in 25 years Dr. Otis has served the hospital without a vacation and has been on call 24 hours of every day to provide important x-ray service for everyone.

All of the speakers were united in expressing their esteem for the veteran radiologist, who began his specialty when the science was in its infancy and progressed with its technical advancement.

Highlight surprise of the evening for Dr. Otis was the arrival of his daughter, Miss Cynthia Otis from New York, where she had given a concert the previous afternoon, to play several harp selections in honor of her father. She was introduced by her uncle, Dr. I. S. Otis.

Dr. David P. Smith was toastmaster and speakers included Dr. Raymond V. Quinlan of Meriden who said he sent the first radiology patient to Dr. Otis; Dr. Mark T. Sheehan of Wallingford who lauded the x-ray specialist for "his gracious and helpful advice," expressing his high personal regards. Also Dr. James McGaughey of Wallingford, Dr. Rueben H. Thalberg of Southington, C. W. Rush, Jr., president of the Bradley Memorial Hospital, Southington, Drs. E. M. Simmons, George M. Connor, and E. S. Bundy, all of Southington.

Principal speaker was Ralph T. Ogden, noted radiologist of Hartford, who spoke highly of Dr. Otis' career devoted to the advancement of his profession.

Dr. Otis was given a beautiful sterling silver tray inscribed to commemorate the high regard expressed by the testimonial, while a large bouquet of red roses was handed to his daughter at the conclusion of her concert.

New Haven County Polio Group Elects

Professor Ira V. Hiscock, chairman of the Department of Public Health, Yale University School of Medicine, was re-elected head of the New Haven County Chapter of the National Foundation for Infantile Paralysis at the organization's recent annual meeting.

Dr. George G. Fox, of Meriden, and Martin Cataneo, New Haven, were elected vice-presidents, Matthew Birmingham, New Haven, secretary, and Clifford E. Smith, New Haven, treasurer. Dr. Joseph I. Linde, New Haven's health officer, was re-elected chairman of the executive committee. Approximately 100 members of the chapter attended the meeting, held at the residence of the New Haven County Medical Association on June 25.

Open Forum at State Pharmaceutical Convention

The joint committee of the Connecticut State Medical Society and the Connecticut Pharmaceutical Association held an open forum on Wednesday, June 23, at the 73rd annual convention of the pharmaceutical group. Problems of mutual concern to physicians and pharmacists were discussed. The forum was organized by Louis E. Kazin, secretary of the Joint Committee and was presided over by him. Four sets of prepared addresses served to introduce the general discussion. These preliminary addresses covered the relations between the physician, pharmacist and patient; the relation of the pharmaceutical profession to the care of veterans; the dispensing of drugs by physicians; and the current problems involved in narcotic control. An effort was made to single out for major discussion problems which could be effectively approached by the concerted efforts of pharmacists and physicians. There was general agreement that efforts should be made to encourage the use of official names of preparations in order to reduce the cost of prescriptions to patients and to minimize the number of reduplicated items on the druggist's shelf. There was also general agreement that some more uniform system for renewing prescriptions containing barbiturates should be evolved.

The medical representatives on the panel were Col. William B. Smith, M.D., Surgeon General of Connecticut, Benjamin V. White, M.D., Samuel A. Schuyler, M.D., Chief Medical Officer at the Hartford Regional Office of the Veterans Administration, and John H. Foster, M.D., of the Connecticut State Committee on Drug Addiction. The pharmacists represented on the panel were Mr. Albert Golden of Bridgeport, Mr. Raymond E. Mercier of Plainfield, Mr. Francis B. Cole of Elmwood, and Mr. Edward C. Burt of the Sachem Laboratories, New Haven.

Rural Health at Farm and Home Week

Mrs. Charles Sewell, of Chicago, director of the Associated Women of the American Farm Bureau Federation, and Dr. Joseph H. Howard, of Bridgeport, chairman of Connecticut's Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, will be the principal speakers on a program being arranged by the Society's Committee on Rural Medical Service as a feature of the annual Farm and Home Week at the University of Connecticut.

The program is scheduled for Wednesday morning, August 11. Mrs. Sewell will speak on the general subject of rural health, and Dr. Howard will discuss the state's program for care of the chronically ill and aged with special emphasis on the problems of rural communities.

The program was announced recently by Norman H. Gardner, East Hampton, chairman of the Committee on Rural Medical Service. Other members of the committee are David H. Bates, Putnam; Gaert S. Gudernatch, Sharon; William H. Upson, Suffield; and James F. Ferguson, Wallingford.

Nurses Fees Raised July 1

Waterbury nurses have joined those in several other areas in Connecticut in raising their fees for private duty nursing to $8 for an 8 hour day, effective July 1. In addition nurses caring for patients in a state of serious mental disturbance will charge $1 daily in addition, and for more than the 8 hour day $1.12 an hour. South of Bridgeport nurses already have been receiving $10 for an 8 hour day.

A.M.A. — JUNE 21-25 — CHICAGO

It is becoming increasingly apparent that the nual sessions of the American Medical Association ve such a full menu to offer that it is impossible r one individual to encompass the entire program. ,963 Fellows of the AMA registered this year om every state and territory in the Union. Guests tended from almost every other nation on the ce of the globe. Many arrived early to attend ses- ons of the American College of Chest Physicians, e American Heart Association, the American ollege of Radiology, the American Society for the udy of Sterility, as well as the Third National onference of County Medical Society Officers, and e Fourth Annual Conference of Presidents and ther Officers of State Medical Associations. The ounty Society conference concerned itself with e subject, "The Job of the County Medical ciety," covered by 3 panel discussions. Thomas J. anaher of Torrington discussed the organization sponsibilities in the panel devoted to The Respon- ility of the County Society to Its Membership. seph H. Howard of Bridgeport presented before e Conference of Presidents the first paper on the rogram entitled "Despotism by Consent of the overned." Dr. Howard was elected president of e Conference for 1948-1949.

CIENTIFIC EXHIBITS

Four major activities occupied the physicians uring the Chicago sessions: the scientific exhibit; e technical exhibit; the scientific meetings where tween 300 and 400 papers dealing with the latest lvances in medicine and surgery were presented; d the meetings of the House of Delegates. The ientific exhibits were exceptionally fine this year. he Gold Medal in Group I, original investigation, ent to a group from the University of Chicago and rgonne Laboratory for an exhibit on the tempor- y control of heparinemic hemorrhagic disease. In roup II, excellence of presentation and correlation facts, the Gold Medal went to Bertha A. Klein Chicago for an exhibit on diseases of the fundus uli. J. Whitfield Larrabee of Hartford partici- ated in the special demonstration of supracondylar actures of the forearm.

ELEVISION

The television program planned by Northwest- n University School of Medicine in cooperation with the AMA, the Radio Corporation of America, Passavant Hospital and E. R. Squibb & Sons marked the first time this method had been used on such a large scale for medical purposes. Television broadcasts were in operation each day of the convention and were so arranged over a closed circuit that about 1,500 could witness a single demonstration simultaneously. Several radio broadcasts were also carried out with headquarters at Navy Pier.

THE ART EXHIBIT

Continuing out beyond the Scientific Exhibits on the Navy Pier one encountered 983 works of art by physician artists comprising the Tenth Annual Exhibition of the American Physicians Art Association. Several Connecticut physicians received Awards of Merit for their productions but none brought home any 1st, 2nd or 3rd prizes this year. Among the winners of the Silver Stars were John M. Freiheit of Waterbury for his charcoal of "Good Companions;" Walter Grossman of Hartford for each of two portraits and also for a linoleum block print; J. Louis Jack of New Haven for two oils, one a non objective opus and the other a portrait of his late brother, Dr. G. J. Jack; Leo Litter of Hartford for a colored photograph of "The Haunted Sentry Box, San Juan;" and Herbert Thoms of Hamden for a dry point entitled "The House by the Tracks." Other Connecticut entrants were Irving S. Dichter, J. Nemoitin and Norman L. Schmidt of Stamford, Louis A. Pierson of Meriden, Charles N. Sullivan of New Britain, and Louise D. Larimore of Greenwich. Drs. Freiheit and Litter are to be especially commended for their awards as novices in their respective fields. The entire art exhibit showed a distinct improvement over the collections secured during the war years with their grotesque patterns and weird conceptions of beauty. A few old friends were missed this year, William W. Wright of Hartford and a recent contributor, Archibald S. Deming of Hartford. The American Physicians Literary Guild had 55 entries of essays, novels, short stories, plays and poems, none by any Connecticut physicians, however.

TECHNICAL EXHIBITS

Each year the latest gadgets, drugs, foods and books find their way to the Technical Exposition. 600 units of space stretched over the vast expanse

of the upper deck of the Navy Pier housed six long rows of fine displays. The individual booths were attractive and accessible, the only drawback was contributed by the weather man, a spell of intense humid heat.

HOUSE OF DELEGATES

The official delegates from the State Societies this year had difficulty attending any scientific sessions or visiting the exhibits before the last day of the convention, so full was the business agenda of the House of Delegates. Dr. Howard was our only delegate at this session assigned to a reference committee, that on medical education. Dr. Murdock as chairman of the special committee to study the nursing problem presented in a concise form the result of a great amount of time and work expended by that committee. Its recommendations are of such vital importance to the practice of medicine that this report appears elsewhere in this issue of the JOURNAL. The principal recommendations concern the training of two grades of nurses and the continuation of a joint committee with the American Hospital Association and the American Nurses Association. The House approved the report.

DISTINGUISHED SERVICE MEDAL

Isaac Arthur Abt, distinguished Chicago pediatrician, received the 1948 Distinguished Service Medal, awarded annually for scientific advancement in the field of medicine. Three candidates were ballotted on by the House of Delegates, Alfred Blalock of Baltimore, Seale Harris of Birmingham, and Dr. Abt. The recipient is a native of Illinois, a graduate of Chicago Medical College, and for 33 years professor of diseases of children at Northwestern University Medical School.

NEW CODE OF ETHICS, CONSTITUTION AND BY-LAWS

Much of the time of the House of Delegates was concerned with accepting, paragraph by paragraph, a new edition of "Principles of Medical Ethics" and a revision of the "Constitution and By-Laws of the American Medical Association." Time consuming as was the discussion of both of these instruments of organization and practice of medicine, their importance was not overlooked and the House had the satisfaction of completing the task before adjournment.

Many were the resolutions introduced on the floor. They concerned for the most part prepaid medical care plans, practice of medicine by hospitals, the resident and intern training program, blo banks, and national emergency medical service.

PREPAID MEDICAL CARE PLANS

Dr. Paul Hawley addressed the House in exec tive session, appealing for the united support the profession of Blue Shield and Blue Cross and the national association of these plans now und his leadership. He reminded his audience that this the last opportunity to offer the public a progra of prepaid medical and hospital care or be regiment by those who would have a federal plan of co pulsory health insurance. 51 separate plans in Bl Shield, according to Dr. Hawley, are not prac cable. The American Medical Association headqua ters office was criticized by several resolutions f its lack of support of voluntary prepaid plans f its own employees. Resolutions calling for a stu of the temporary disability program and of t compulsory cash sickness insurance program we referred to the Board of Trustees as this group h such a study underway at the present time.

PRACTICE OF MEDICINE BY HOSPITALS

The same old apparition appeared in the 19 session of the House of Delegates as had visit previous sessions, the encroachment of hospitals the practice of medicine. The Bureau of Leg Medicine and Legislation was requested to make study of the State laws concerning the practice medicine and to prepare uniform legislation cove ing the same. The House of Delegates voted t send an official communication to hospitals an medical schools defining its position on this matte A resolution to refuse hospitals the privilege training interns where physicians' services we being used by the hospital for profit was referred t the Board of Trustese now investigating this pro lem. The appointment of general practitioners t hospital staffs was approved.

MEDICAL EDUCATION

The entire problem of medical education and in tern placement received considerable attentio Grave concern was expressed over the financial out look for medical schools. Students' fees are pro viding only 28 per cent or less of the budgets medical schools. The Board of Trustees has bee requested to consider carrying out a campaign t inform the citizens of the nation of the need fo more generous support of medical schools fro private sources and to form a National Foundatio

for this purpose. Hospitals not conforming to the Uniform Intern Placement Plan now in operation are to be reported to the Council on Medical Education and Hospitals for investigation and appropriate action. The House disapproved federal subsidy of medical education as written into the Academy of Pediatrics' plan. The Council on Medical Education and Hospitals was asked to investigate medical student organizations favoring communism, to confer with medical schools for the purpose of taking appropriate action.

BLOOD BANKS

From a number of resolutions relating to blood banks came the recommendation that these should be under the local control of the county medical societies, that the local city society should be the contact in the initial contemplation of inauguration of a new blood bank, that any changes be arbitrated at State levels by the medical society and the Red Cross, and that there be no publicity except by mutual consent of the local county medical society and the local chapter of the American Red Cross.

NATIONAL EMERGENCY MEDICAL SERVICE

In its report to the House of Delegates the Council on National Emergency Medical Service enunciated 9 principles. These were accepted with very few changes. The resolution to have but one physical examination at place of induction into the service was voted down. Each state and component county society was requested to appoint a committee on National Emergency Medical Service within its organization. A resolution was passed calling for remuneration for physicians serving on induction boards to be on fee basis. Another resolution was passed offering the services of the AMA to the Armed Forces in formulating plans for the integration of physicians for medical service, and also calling for a survey of the physicians of the country and of the civilian needs with this end in view. The House voted to request equitable rank for civilian physicians serving in peace in the Armed Forces with those serving in time of war. It was voted to recommend to advance the rank of the Surgeons General of the Army, Navy, and Air Force.

CANCER DETECTION CENTERS

It was voted that the AMA, the American Cancer Society, and other interested groups cooperate in developing standards to operate Cancer Detection Centers.

Life insurance companies are already considering increasing fees for medical examinations, hence the resolution dealing with this question was referred to the Bureau of Economic Research.

The House voted to protest to the Children's Bureau their ruling designating only certified orthopedic surgeons for care of children under the Bureau and to request the Federal Security Administrator to appoint physicians qualified on the State level.

Hospital and medical care of veterans is to be arranged between the State Society and the Veterans Administration. Congressional action is to be requested for an interpretation on the establishment of a ceiling on the number of beds to be supplied.

Federal grants-in-aid for medical and health services to States were opposed except where the need is demonstrated.

A resolution was passed setting up the method of selecting the outstanding general practitioner each year through county and state societies to AMA House of Delegates.

An attempt was made to pass a resolution opposed to excluding from membership in a county medical association and hence in the AMA any physician because of race, creed or color. This was rejected on the ground that the county association should have the prerogative of determining its own rules of membership.

ADMIRAL SWANSON APPEALS TO CIVILIAN PHYSICIANS

Rear Admiral C. A. Swanson, M.D., Surgeon General of the Navy, pointed out the large medical program being carried out by Naval Medical Officers, not only among Navy and Marine personnel, but for the civilian population on many an outpost. He expressed his agreement with the necessity for deferment of induction of premedical, medical and scientific students, as well as medical professors and research scientists. He closed his remarks with an appeal to civilian medicine to discharge its responsibility to the U. S. Navy.

NEW AMA OFFICERS

Edward Ernest Irons of Chicago was chosen president-elect for 1948-1949. Roscoe L. Sensenich of South Bend was installed as president. The other newly elected officers for the coming year are Vice-

President, Roy W. Fouts, Omaha; Secretary, George F. Lull, Chicago; Treasurer, Josiah J. Moore, Chicago; Speaker of House of Delegates, F. F. Borzell, Philadelphia; Vice-Speaker, James R. Reuling, Bayside, N. Y.; Trustees: Gunnar Gundersen, La Crosse, Wisconsin; Edwin S. Hamilton, Kankakee, Illinois; Walter B. Martin, Norfolk, Virginia; Judicial Council, John H. O'Shea, Spokane; Council on Scientific Assembly, Alphonse McMahon, St. Louis; Council on Medical Education and Hospitals: Harvey B. Stone, Baltimore, and William L. Pressle Due West, S. C.; Council on Medical Service: Hen B. Mulholland, Charlottesville, Va., and Joseph I McCarthy, Omaha.

COMING SESSIONS

The next AMA session will be the Second Annu Interim Session at St. Louis, November 30 to D cember 3, 1948. The 1949 Annual Session will b held in Atlantic City, 1950 Session in San Francisc and the 1951 Session in Atlantic City.

CONNECTICUT PHYSICIANS ATTENDING AMA CONVENTION

Bridgeport
Antell, Maxwell J.
Booe, J. Grady
Curley, William H.
Deren, M. David
Kaplan, Leon
Levinsky, Maurice
Weise, Elwood C.

Bristol
Ciccarelli, Armanno W.
Czyz, Stanley I.

Cheshire
Neff, William E., Jr.

East Hampton
Gardner, Norman H.

Farmington
Bunnell, Walls W.

Groton
Barnum, Charles G.

Hartford
Delligan, Francis W.
Felty, A. R.
Goldstein, Max R.
Gray, Albert S.
Hennessy, James J.
Hutchison, J. Elder
Kaschmann, Joseph
Larrabee, J. Whitfield
Martin, Stevens J.
Osborn, Stanley H.
Priddy, Foster E.
Roberts, Douglas J.
Seibert, A. F.
Standish, E. Myles
Talbot, Henry P.
Taylor, A.
Tovell, Ralph M.
Weld, Stanley B.
White, Benjamin V.
Worthen, T. W.

Meriden
Caplan, Max
Murdock, Thomas P.

Middletown
Grower, Julius H.
Seinfeid, Edward D.
Tracy, F. Erwin

New Britain
Dorian, George D.

New Haven
Arnold, Hermann Bruno
Barker, Creighton
Calabresi, Massimo
Creadick, A. Nowell
Day, Harry Luther
Geiger, Arthur J.
Gentile, Angelo L.
Johnson, Carl E.
Kleiner, Simon B.
Marvin, H. M.
Quinn, Robert W.
Serafin, Peter J.
Shumacker, Harris B., Jr.
Whittemore, Ruth

Norfolk
Barstow, Richard I.
Ursone, Frank D.

Norwich
Danburg, Dwight S.

Portland
Schwartz, Philip E.

Putnam
Prosser, Florence

Riverside
Meeker, D. Olan

Stamford
Kezel, Albert P.

Torrington
Danaher, Thomas J.
Wallach, Gert M. K.

Waterbury
Bizzozero, Orpheus J.
Freiheit, John M.
Harvey, Joseph L.
Kelly, LeMoyne C.
Kirschbaum, Edward H.

Watertown
Meyers, Royal A.

FACTS ARE A SOLID FOUNDATION

People are sometimes misled by colorful words erected on a flimsy foundation of fact. This is one form of propaganda.

Public relations must see that words and facts are in honest agreement. Otherwise good relationships are endangered.

Facts Are The Basis Of Good Relationships

NEWS FROM WASHINGTON

Health and Medical Bills Passed by 80th Congress

S1454, which amends the Public Health Service Act regarding certain matters of personnel and administration. Puts commissioned corps of PHS on parity with Army and Navy as regards pay and promotion.

S176 and HR676, providing for creation of a National Institute of Dental Research.

S2215, providing for the creation in the Public Health Service of a National Heart Institute comparable to National Cancer Institute. Signed by President on June 18 (Public Law 655).

S1969, amending the Philippine Rehabilitation Act of 1946 to provide for the training of Filipinos in public health methods.

S2341, authorizing an increase of $100,000 in the annual appropriation for the Gorgas Memorial Laboratory.

HR4114, amending the PHS Act to permit expenditures for operating purposes.

HR6339, amending the Hospital Survey and Construction Act so as to enable States which would cease to be eligible because of inability to pay to participate in the program.

HR6289, providing for the voluntary admission and treatment of mental patients in St. Elizabeth's Hospital.

SRes.249, providing for study of Nation's health problems and of legislative proposals relating thereto.

BILLS FAILING TO PASS

The National Science Foundation bill passed the Senate in sadly amended form (S2385) but died in the House.

S140, to create a Department of Health, Education, and Security with a Cabinet officer, never got off the Senate calendar.

PASSED OVER PRESIDENT'S VETO

HJRes.296, designed to retain status quo with respect to certain employment taxes and social security benefits, was passed over the President's veto.

HR6355, the Supplemental Federal Security Appropriation bill for 1949, was passed over the President's veto on June 16 (Public Law 645).

SELECTIVE SERVICE ACT OF 1948

This bill, mutilated almost beyond recognition, finally passed both Houses in the final sessions of Congress after a 17-hour filibuster. The physician draft, after several attempts at inclusion, was dropped.

TWO HEALTH INSURANCE BILLS DEAD

The pending Taft-Smith-Ball-Donnell bill (S545) and the Murray-Wagner,Pepper-Chavez-Taylor and McGrath bill (S1320) are dead. Their fate is the result of introducing into the Senate on June 4 SRes.249 which provides for study of Nation's health problems and of legislative proposals relating thereto.

Senator Taft's statement in support of SRes.249 is important. In part, this statement reads:

"The problems involved in the consideration of health legislation are numerous and frequently complex. Yet, certain fundamental issues have emerged from the findings of the Subcommittee which require further investigation and study, as a prelude to any broad recommendations governing health legislation!

"*First:* The issue involves consideration of (1) the state of the health of the population, (2) the distribution of the nation's medical, hospital, dental and other health services, and (3) whether or not the majority of the population has access to such services.

"*Second:* There is a fundamental question as to whether, and to what extent, it is necessary for the Federal government further to expand its operations in the field of health.

"*Third:* The basic issue involved in the provision of medical and certain other health services for individuals, in the event of further Federal expansion in this field, rests in the question of methods or systems to be employed.

"*Fourth:* It is apparent that individual measures in proposed health legislation must be considered in

proper perspective rather than individually. It is further apparent that health legislation as a whole, enacted and proposed, must be considered in relation to other broad welfare programs of government. The fundamental issue here is that of ascertaining the long-range effects of such proposals as compulsory health insurance and wide-scale grant-in-aid programs, assuming they were to be adopted and their resultant tax levies and regulatory requirements were added to those already existing.

"*Fifth:* There is a basic question as to the proper administrative organization for dealing with health functions.

"*Sixth and finally:* It is a matter of fact, although frequently overlooked in testimony before the Subcommittee, that health does not exist in a vacuum. Instead, health is the net result of the working of a very considerable range of environmental, personal and other interrelated factors. Legislation providing medical care alone, for example, will not necessarily guarantee the prevalence of good health. Should there be also an extension of the present Federal Public Health Program?"

Navy's New Medical Training Program

The Surgeon General of the Navy has announced the expansion of the Bureau's professional training program for reserve and regular medical officers, which is similar to the recently expanded Army medical training program. The object is to permit more Navy doctors to meet the requirements for certification by the various American Specialty boards, and to encourage the young doctor to intern under the auspices of the Navy. The following are the important points in this program:

Graduates of Class A medical schools who have been accepted for internship by a hospital approved for such training by the Council on Medical Education and Hospitals of the AMA may be commissioned as lieutenant (junior grade), MC—USNR, and permitted to continue their intern training. They will receive all the pay and allowance of the rank while so serving. After completing their internships, the medical officers must remain on active duty for a period of one year. If they meet the professional, physical and moral requirements, they will be given every encouragement to transfer to the regular Navy.

Interns who have completed the one year of obligated service, and who have transferred to the regular Navy, may be considered for residency training on a competitive basis with other officer personnel of the regular Medical Corps.

Resident physicians now in civilian hospitals, or those accepted for approved residency training, are eligible for commissions in the regular Navy. Those so commissioned will be assigned to duty, with full pay and allowances, in the hospital in which they are already a resident, or to which they have been accepted for residency training. Every attempt will be made to permit residents holding commissions in the regular Navy to complete their training in event of an emergency.

The Navy has at the present time 400 approved residencies and fellowships in the various specialties recognized by the American Specialty Boards in Naval and civilian hospitals. This educational training involving the 400 residencies is divided into two programs.

Program A: One hundred of the above mentioned residencies, courses, and fellowships will be made available for civilian physicians accepting a commission in the U. S. Navy. An additional 100 civilian physicians will be commissioned in the U. S. Navy and permitted to pursue their own course, fellowship or residency, provided it is approved by the Council on Medical Education and Hospitals of the American Medical Association with concurrence of the Specialty Board. Upon acceptance of the designated training, they will be required to agree to remain in the Navy for a certain obligated time.

If on original appointment a candidate has not been approved for more than one year of training, during his first year of residency training (Program A) he may compete for one of the 300 residencies (Program B) available to the Regular Naval medical officers, and if he obtains such training he will obligate himself to remain on active duty for an additional period depending upon the amount of time spent in training.

Program B: Three hundred residencies, fellowships or courses, will be reserved for continuing the Training Program as presently organized for regular medical officers.

The obligated service following graduate medical training (courses, fellowships and residencies) in Naval hospitals is one year for each year of training received.

Information concerning any part of the program may be obtained by writing to the Chief of the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*

Egbert M. Andrews, Hartford
Joseph J. Bruno, New Haven
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Authorization for Treatment of Veterans

Veterans who wish to have their service connected disabilities treated by a Veterans Administration fee-basis physician must first obtain prior authorization from the VA.

"If a veteran goes to a VA fee-basis physician to have his service connected disability treated without VA authorization," Harry T. Wood, manager of the Hartford VA Regional Office, explained recently, "he may have to pay the expenses himself.

"The method of obtaining treatment by a VA fee-basis physician has been simplified to the extent that there is a minimum of necessary paper work.

"But, in order to have the VA pay expenses, the veteran must have prior authorization. He can obtain this authorization by contacting the medical unit of his nearest VA office."

New Artificial Leg Prosthesis

Special courses to acquaint physicians with the fitting of a new type of artificial leg which requires no suspension harness are now being conducted by the Veterans Administration in several sections of the country, as reported in the February 1948 issue of the *Journal.*

Known as the "suction socket prosthesis," the artificial limb is held in place by a moderate vacuum created when it is attached to the stump, and maintained by normal walking. The area of vacuum within the socket is controlled by a small valve, easily operated by the amputee.

At the present time the suction socket is frankly experimental, and its use is encouraged only in cases where the above-knee amputation is such as to permit proper fitting.

One of the special courses in the fitting of the new prosthesis was recently held in New York and attended by Dr. Joseph J. Bruno and Dr. Russell V. Fuldner of New Haven.

Life Insurance Term Policies

National Service Life Insurance term policies owned by veterans may be renewed for an additional 5 years upon expiration of the present term period, according to Arthur M. Grayson, Veterans Administration Insurance Officer for the Hartford VA Regional Office.

NSLI term policies purchased before January 1, 1946 have an 8-year term period from date of issue. Term policies issued after that date are for a 5-year term. Recently enacted Public Law 838 makes it possible for veterans to renew their term policies for another 5-year period when their present term expires.

When they renew their term insurance, veterans will pay a new, higher premium based on their attained age at time of renewal.

Addition of another 5 years for term NSLI policies was made possible under provisions of Public Law 838 passed by last Congress.

Disabilities Less Than 10 Per Cent

Veterans who are notified by the Veterans Administration that their service connected disability is rated as less than 10 per cent will not receive monetary compensation, according to a recent announcement.

Only those veterans whose disabilities are rated 10 per cent or more can qualify for compensation payments.

VA Dental Laboratory

New England veterans are now assured of improved service in the making of dentures and other prosthetic appliances through the operation of a new dental laboratory at the Boston Branch office of the Veterans Administration.

Since the laboratory opened on April 14, 250 dentures have been furnished to veterans. The staff

ncludes nine dental technicians, under the direction f S. F. Hardy, D.D.S. Prior to April, orders from /A dental clinics throughout New England were ent to New York City, and sometimes several eeks elapsed before they were filled. Since the oston laboratory opened, all orders have been filled n from four to seven days.

THE DOCTOR'S OFFICE

James T. Anderson, M.D., announces the opening f an office for the practice of pediatrics at 899 Main treet, Willimantic.

Robert A. Bonner, Jr., M.D., announces the repening of an office for the practice of general rgery at 43 Central Avenue, Waterbury.

John E. Cartland, Jr., M.D., announces the opening of an office for the practice of pediatrics at 576 armington Avenue, Hartford.

Vincent J. Grillo, M.D., announces the removal of is office to 85 Trumbull Street, New Haven.

Winston C. Hainsworth, M.D., announces the pening of an office for the practice of pediatrics at 70 Main Street, Willimantic.

Francis W. Helfrick, M.D., announces the opening f an office for the practice of pediatrics at 186 East enter Street, Manchester.

J. F. Jones, M.D., announces the opening of an ffice for the general practice of medicine at 39 road Street, Danielson.

William C. McGuire, M.D., announces the removal of his office to 5 Elm Street, New Haven.

Henry M. Pollock, Jr., M.D., announces the opening of an office in Bristol.

William F. Priestley, M.D., announces the opening f an office for the practice of internal medicine at 41 Asylum Avenue, Hartford.

M. Walter Radowiecki, M.D., announces the pening of an office for the general practice of edicine and surgery at 312 Main Street, Ansonia.

David G. Rosseau, M.D., announces the opening of n office for the practice of medicine and surgery n the Ponemah House, Taftville.

Edward H. Scheer, M.D., announces the opening of an office for the general practice of medicine at 9 Franklin Square, New Britain.

Robert M. Steel, M.D., announces the opening of an office for the general practice of medicine at 2742 Main Street, Stratford.

Kenneth G. Washington, M.D., announces the opening of an office for the practice of medicine at 74 Asylum Street, Hartford.

John B. Wells, M.D., announces the opening of an office for the practice of internal medicine at 580 Asylum Street, Hartford.

William E. Wilson, M.D., announces the opening of an office for the practice of medicine at 40 High Street, Bristol.

New Haven Physicians Speak at National Convention

Two New Haven physicians, Peter J. Serafin and Robert F. Scholl, were discussants of the subject "Surgical Therapy in Jaundice" at the 13th annual convention of the National Gastroenterological Association held recently at the Hotel Pennsylvania, New York City.

The clinical lecture on the subject was delivered by Dr. Walter B. Crandall, chief of surgery at the Veterans Administration Center, White River Junction, Vermont. Convening on June 7, the 4-day annual gathering was attended by approximately 100 physicians.

Blue Shield Financial Report for 1947

Blue Shield plans recorded a total income of $48,445,245 during 1947, according to a financial report released recently from their national office in Chicago.

Payments to physicians totalled $37,942,749, amounting to 78.14 per cent of the annual income, $7,461,570 was expended for operating expense during the year, accounting for 15.37 per cent of the total income. The balance of $3,154,186, or 6.49 per cent, was added to reserve accounts.

Blue Shield plans have accumulated $20,881,546 in assets during the past few years, of which $9,947,547 are held in reserve accounts for contingencies of various kinds.

MILITARY BIOGRAPHIES (*Continued*)

These brief sketches of military experience of members of the Society have been compiled from data taken from questionnaires completed by each medical officer. Biographical material for some officers is lacking because questionnaires were not returned.

MANGANIELLO, LOUIS O. J., Waterbury; b. 1915; Maryland 1942; Navy—July 9, 1943 Lt. (j.g.), Lt. November 1, 1944; Service Terminated September 3, 1946; Duty—School of Neuropsychiatry; Portsmouth, Va.; Norfolk, Va.; Philadelphia, Pa.; Camp LeJeune, N. C.; Corps Evacuation Hosp. #1—2nd Marine Division (Asiatic-Pacific Theatre of Operations); St. Albans, N. Y.; Award—Letter of Commendation.

MARGOLICK, MOSES, Putnam; b. 1910; McGill 1935; Army—May 7, 1943 Lt., Captain November 16, 1944; Service Terminated January 24, 1946; Duty—3rd Air Force—5th Aux. Surg. G.P., 9th Army—European Theatre of Operations; Awards—4 campaign stars; Unit Citation; Certificate of Merit.

MARGOLIUS, NORMAN C., Waterbury; b. 1907; Cornell 1933; Army—October 8, 1942 Captain, Major July 1943, Lt. Colonel November 1945; Service Terminated January 28, 1946; Duty—Continental United States; 303rd Station Hospital—77th Station Hospital (European Theatre of Operations).

MARKLE, RAYMOND D., Waterbury; b. 1910; Syracuse 1937; Army—August 15, 1942 Lt., Captain October 2, 1943; Service Terminated January 3, 1946; Duty—Field Medical Service School, American Center, England; School of Military Neuropsychiatry; Camp Gordon, Ga.; Camp Forrest, Tenn.; Ft. Leonard Wood, Mo.; Desert Maneuvers; European Theatre of Operations; Awards—Bronze star; Combat Medical Badge; Distinguished Unit Citation.

MARTIN, JOHN E., Norwich (Entered service from Cranston, R. I.); b. 1913; Dalhousie 1942; Navy—December 11, 1942 Lt. (j.g.), Lt. January 1944, Lt. Comdr. January 1946; Service Terminated April 21, 1946; Duty—Bethesda, Md.; School of Aviation Medicine, Pensacola, Fla.; Norfolk, Va.; Asiatic-Pacific Theatre of Operations; Quonset Point, R. I.

MARTIN, JOHN G., West Hartford; b. 1907; Yale 1933; Army Air—July 16, 1943 Lt., Captain June 14, 1944; Service Terminated April 7, 1946; Duty—Kelly Fld., Tex.; Tinker Fld., Okla.

MARTIN, RAYMOND A., Bridgeport.

MARTIN, STEVENS J., Hartford (Entered service from Viroqua, Wisconsin); b. 1906; Wisconsin 1935; Army—July 1, 1941 Lt., Captain January 1, 1942, Major July 9, 1942, Lt. Colonel September 6, 1945; Service Terminated May 19, 1946; Duty—Tilton General Hospital, Ft. Dix, N. J.; Award—Letter of Commendation.

MASSEY, DANIEL M.. Bridgeport; b. 1908; Hahnemann 1936; Army—July 1, 1942 Captain, Major November 1945; Service Terminated January 8, 1946; 9th Evacuation Hospital — England-Africa-Sicily-Italy-France-Germany; Awards — Legion of Merit; Bronze Arrowhead; European Theatre Ribbon w/6 battle stars.

MASTRANGELO, ANGELO, JR., Stamford (Entered service from Revere, Mass.); b. 1911; Boston University 1939; Army Air—September 28, 1942 Lt., Captain December 2, 1943; Service Terminated January 18, 1946 (Major); Duty—School of Aviation Medicine, Randolph Fld., Tex.; School of Applied Tactics, Orlando, Fla.; Mediterranean Theatre of Operations; Awards—European Theatre Ribbon w/9 battle stars; Air Medal; Bronze star; Unit Citation w/1 oak leaf cluster.

MATHEWS, FRANK P., New Haven; b. 1905; Harvard 1930; Navy—May 1, 1941 Lt., Lt. Comdr. December 1, 1942; Service Terminated April 4, 1945; Duty—Coco Solo, C. Z.; Ft. Schuyler, N. Y.; School of Epidemiology, Bethesda, Md.; Philadelphia, Pa.; San Diego, Calif.; Seattle, Wash.; Asiatic-Pacific Theatre of Operations.

MAURER, WILLIAM S., Willimantic (Entered service from New York City); b. 1909; Yale 1938; Army Air—June 29, 1942 Lt., Captain July 1, 1944; Service Terminated April 14. 1946 (Major); Duty—Tallahassee, Fla.; School of Aviation Physiology, Randolph Fld., Tex.; Wright Fld., Ohio; Tampa, Fla.; Ft. [illegible] Moines, Iowa; School of Tropical M[illegible] cine.

MAYNARD. HARRY H., New Hav[illegible] b. 1887; Yale 1916; Army—February 1941 Lt. Colonel (Transferred to Ar[illegible] Air April 14, 1942); Service Termina[illegible] August 2, 1945 (Colonel); Retired B[illegible] General; Duty—Wright Fld., O[illegible] Cleveland, Ohio; Ft. Hayes; 12th G[illegible] eral Dispensary (European Theatre Operations); School of Aviation M[illegible] cine; (Died January 8, 1948).

MAYO, ELLIOTT R., Waterbury; [illegible] 1909; Tufts 1938; Navy—March [illegible] 1943 Lt.; Service Terminated Novem[illegible] 12, 1945; Duty—Great Lakes, Ill.; Eva[illegible] ation Hosp. #1; Camp Lejeune, N. [illegible] Sub. Base, New London, Conn.

McCABE, EDWARD J., New Ha[illegible] (Entered service from New York Cit[illegible] b. 1899; Yale 1926; Navy—February [illegible] 1943 Lt. Comdr.; Service Termina[illegible] December 16, 1945; Duty—Officer P[illegible] curement, New York, N. Y.; V-12 U[illegible] Yale University, New Haven, Conn.; [illegible] S. Naval Hospital, Newport, R. I.; ([illegible] moved to New York).

McCRANN, DONALD J., Hartford; [illegible] 1909; Tufts 1934; Navy—May 17, 1[illegible] Lt., Lt. Comdr. October 3, 1945; Serv[illegible] Terminated February 21, 1946; Dut[illegible] Norfolk, Va.; Jacksonville, Fla.; P[illegible] Hueneme, Calif.; Naval Base Disp.—I[illegible] Jima (Asiatic-Pacific Theatre of Op[illegible] tions; Brooklyn, N. Y.

McCUE, MARTIN P., East Hartford

McDONNELL, RALPH E., New Hav[illegible] b. 1894; Yale 1920; P.H.S.—June [illegible] 1942 Surgeon; Service Terminated J[illegible] 1, 1947; Duty — Connecticut E.M[illegible] (Died November 24, 1947).

McGAUGHEY, J. DAVID, III, W[illegible] ingford; b. 1918; Jefferson 1944; N[illegible] —July 17, 1945 Lt. (j.g.); Service T[illegible] minated September 16, 1946; Duty—[illegible] Albans, N. Y.; Great Lakes, Ill.; U[illegible] Teton (AGC #14); USS APL 24; [illegible] Diego, Calif.

GUIRE, FRANK J., Guilford.

EON, JAMES J., Hamden.

ELLAN, PHILIP G., Hartford; b. 9); Harvard 1925; Navy—December 942 Lt. Comdr., Commander July 1945; Service Terminated December 945; Duty—Brooklyn, N. Y.; Philahia, Pa.; Camp Peary, Va.; Corps uation Hospital #1—Marines & Amphibious Corps (Asiatic-Pacific atre of Operations); Award—Marine ition on Iwo Jima.

LEOD, CHRISTIE E., Middletown; 909; Vermont 1934; Navy—March 1944 Lt.; Service Terminated May 6, 5; Duty—U. S. Naval Hospital, New, R. I.

MAHON, GEORGE W., New Britain.

MAHON, JOHN D., Norwalk; b. 9); Creighton 1937; Army—August 1942 Lt., Captain March 18, 1943; ice Terminated December 29, 1945 jor); Duty—Continental United es.

NAMARA, ALEXANDER P., Bridge-

NULTY, TERRENCE F., Hartford; 908; Georgetown 1932; P.H.S. (US)—December 28, 1942 Asst. Surgeon, Asst. Surgeon December 1943; ice Terminated August 8, 1945; y—Manhattan Beach, N. Y.; Nor, Va.; Berkley, Va.; New Orleans, L.S.T. Flotilla 29; Mobile, Ala.

ACHAM, CHARLES T., Stamford tered service from New York City); 903; Pennsylvania 1930; Navy—Jany 16, 1945 Lt. Comdr.; Service Terated April 12, 1946; Duty—Brook, N. Y.; USS Solace, USS Refuge iatic-Pacific Theatre of Operations); Albans, N. Y.

IGS, J. WISTER, New Haven (Ented service from Seattle, Wash.); b. 5; Harvard 1940; Army—November 1944 Lt., Captain August 18, 1945, jor January 30, 1947; Service Termied July 15, 1947; Duty—Mt. Alto sp., Veterans Adm., Washington, D. Preventive Medicine Service, Office the Surgeon General, Washington, C.; Army Industrial Hygiene Laboraty, Edgewood Arsenal, Md.; Award—ny Commendation Ribbon.

KRUT, JOSEPH A., Meriden; b. 07; St. Louis 1931; Army—August 13, 1943 Lt., Captain August 7, 1944; Service Terminated January 19, 1946; Duty—Carlisle Barracks, Pa.; Camp Grant, Ill.; Ft. Sam Houston, Tex.; 88th Infantry Division—715th Railway Operating Bn. (Mediterranean Theatre of Operations); New Orleans, La., P.O.E., Camp Planche, La.; Awards—4 Bronze campaign stars; Meritorious Battalion Service Plaque.

MELLION, JACOB, New Britain; b. 1897; Yale 1923; Army—July 1, 1941 Captain, Major July 8, 1941, Lt. Colonel May 27, 1944; Service Terminated March 16, 1945; Duty—Ft. Terry, N. Y.; Ft. Wright, N. Y.; Carlisle Barracks, Pa.; 40th Station Hospital—North Africa-Corsica-Allied Hqs. Caserta, Italy (North African-Mediterranean Theatre of Operations); Award—Meritorious Service Award.

MENOUSEK, JOSEPH A., Plainville; b. 1906; Vermont 1932; Navy—June 3, 1944 Lt.; Service Terminated July 10, 1946; Duty—Brooklyn, N. Y.; USS Hooper Island (ARG 17); Japanese Occupation; USS Alcor (Asiatic-Pacific Theatre of Operations).

MERRIMAN, HENRY, Waterbury; b. 1910; Columbia, 1936; Army—July 15, 1942 Captain, Major November 29, 1945; Service Terminated February 22, 1946; Duty—39th General Hospital, Auckland, N. Z., Saipan, M. I.

MESHKEN, JACOB, Bridgeport (Entered service from New York City); b. 1911; Rush 1937; Army—April 1, 1942 Lt., Captain December 10, 1942, Major October 1, 1944; Service Terminated December 20, 1945; Duty—Ft. Jay Station Hospital, N. Y.; 12th Evacuation Hospital; Third Army—109th Evacuation Hospital, Czechoslovakia (European Theatre of Operations); Awards—4 battle stars; Unit Meritorious Service Plaque.

MESSINA, MICHAEL C., Newington; b. 1901; Tennessee 1927; Army—February 23, 1944 Major; Transferred to Veterans Administration; Duty—Veterans Administrations—Newington, Conn., Bay Pines, Fla.

MEYERS, ROYAL A., Watertown; b. 1905; Michigan 1931; Army Air—November 1, 1941 Lt., Captain February 1, 1942, Major January 25, 1943; Service Terminated December 9, 1945; Duty—Grenier Fld., Manchester, N. H.; Richmond, Va.; School of Aviation Medicine; North Africa-Middle Eastern Theatre of Operations; Award—Meritorious Service Plaque.

MEZEY, CORNELIUS M., New London; b. 1890; Royal University of Budapest, (Hungary) 1918; Army—September 15, 1942 Captain; Service Terminated September 25, 1943; Duty—Charleston, S. C., Camp Gordon Johnston, Fla.; (Removed to Great Falls, Montana).

MICHALOWSKI, VALERIAN S., New Britain; b. 1903; Boston University 1929; Army—March 10, 1944 Captain, Major; Service Terminated August 18, 1947; Carlisle Barracks, Pa.; Ft. Sam Houston, Tex.; Camp Campbell, Ky.; Temple, Tex.; 232nd General Hospital, Iwo Jima; 369th Station Hospital, Saipan, M. I.; Waltham, Mass.; Awards—Bronze star; Asiatic-Pacific Theatre Ribbon w/1 battle star; Letter of Commendation; Meritorious Service Unit Citation.

MIDDLEBROOK, LOUIS F., Hartford; b. 1904; Johns Hopkins 1930; Navy—November 29, 1943 Lt. Comdr.; Service Terminated February 1, 1946; Duty—Quantico, Va.; Newport, R. I.

MIGNONE, JOSEPH, New Haven; b. 1909; Yale 1933; Navy—April 19, 1943 Lt., Lt. Comdr. October 3, 1945; Service Terminated March 2, 1946; Duty—Newport, R. I.; Camp Peary, Va.; Norfolk, Va.; Acorn 24, Navy #3205—M.T.B. Ron 21—Base Hospital #15, Navy #3205 (Asiatic-Pacific Theatre of Operations).

MILICI, JOHN J., New Haven; b. 1913; Hahnemann 1940; Navy—March 21, 1942 Lt. (j.g.), Lt. October 1, 1942, Lt. Comdr. October 1, 1944; Service Terminated March 21, 1947; Duty—Chemical Warfare School, Edgewood Arsenal, Md.; Asiatic-Pacific Theatre of Operations; Sampson, N. Y.; School of Military Tactics and Strategy, Quantico, Va.; Brooklyn, N. Y.; Award—Presidential Unit Citation.

MILLEN, SAMUEL R., New Haven; b. 1911; George Washington 1938; Army—January 15, 1943 Lt., Captain November 1943; Service Terminated February 18, 1946 (Major); Duty—Carlisle Barracks, Pa.; Camp Rucker, Ala.; Camp Iron Mountain, Calif.; Camp Myles Standish, Mass.; England - France - Belgium - Germany; Awards—Croix de Guerre w/ etoile de vermeille; European Theatre of Operation Ribbon w/5 campaign stars.

MILLER, GERARD R., Manchesttr.

MILLER, HARRY B., Hartford; b. 1904; Rush 1933; Army—May 1, 1941 Lt., Captain August 1941; Major January 1945; Service Terminated October 5, 1945; Duty—School of Chemical Warfare, Edgewood Arsenal, Md.; Ft. Devens, Mass.; 16th General Hospital—England-Wales-France-Belgium; Ft. Dix, N. J.; Awards—European Theatre of Operation Ribbon w/3 battle stars.

MILLER, HUGH K., Stamford (Entered service from Brooklyn, N. Y.); b. 1904; Columbia 1932; Navy—October 19, 1942 Lt., Lt. Comdr. June 1945; Service Terminated November 29, 1945; Duty—Navy and Marine Recruiting V-12 Program—Albany Medical School, Albany, N. Y.; Pensacola, Fla.; USS Chester (Asiatic-Pacific Theatre of Operations).

MILLER, SEYMOUR M., West Hartford (Entered service from Atlanta, Ga.); b. 1917; Tulane 1941; Army—July 1, 1942 Lt., Captain November 6, 1943; Service Terminated February 24, 1946; Duty—Bn. Surgeon.

MILLS, CLIFFORD W., South Norwalk (Entered service from New York City); b. 1913; Cornell 1938; Army Air—May 27, 1941 Lt., Captain June 1942; Service Terminated December 30, 1945; Duty—School of Aviation Medicine, Randolph Fld., Tex.; Tactical Trainnig Center, Orlando, Fla.; Caribbean; North Africa; Alamogordo, N. M.; San Antonio, Tex.; Lubbock, Tex.; Amarillo, Tex.; Dalhart, Tex.; Camp Croft, S. C.

MIRABILE, THOMAS J., East Hartford.

MISSETT, JAMES S., West Hartford (Entered service from Drexel Hill, Pa.); Army—March 1944 Lt., Captain June 1945; Service Terminated August 29, 1946; Duty—School of Military Neuropsychiatry; Vaughan General Hospital, Michigan; Tilton General Hospital, Ft. Dix, N. J.

MISUK, JOSEPH F., Meriden; b. 1908; Georgetown 1932; Navy—July 10, 1944 Lt.; Service Terminated July 13, 1946; Duty—School of Tropical Medicine; Camp Wallace, Tex.; San Bruno, Calif.; Shoemaker. Calif.; Treasure Island, Calif.; Samar, P. I., Manila (Asiatic-Pacific Theatre of Operations); USS General John Pope.

MITCHELL, GERALD V., Torrington.

MOHER, JAMES J., Hartford; b. 1912; Yale 1937; Army Air—October 17, 1943 Lt., Captain June 1944; Major October 1946; Service Terminated December 1946; Duty—Carlisle Barracks, Pa.; Italy (Mediterranean Theatre of Operations); Puerto Rico; Ft. Dix, N. J.; Memphis, Tenn.; Award—Soldiers Medal.

MOLNAR, GEORGE J., Bridgeport; b. 1916; Georgetown 1943; Army—December 31, 1943 Lt., Captain February 1944; Service Terminated October 3, 1946; Duty—Carlisle Barracks, Pa.; Lovell General Hospital, Mass.; Ft. Dix. N. J.; 135th General Hospital—49th Station Hospital—England (European Theatre of Operations); Award—Unit Citation.

MONACELLA, JOHN M., Windsor; b. 1909; Columbia 1935; Army—February 12, 1943 Lt., Captain October 1943; Service Terminated December 29, 1945; Duty—Continental United States—European Theatre of Operations; Awards—4 battle stars.

MONAGAN, THOMAS M., Waterbury; b. 1914; Harvard 1940; Navy—March 25, 1942 Lt. (j.g.), Lt. October 1942, Lt. Comdr. August 1945; Service Terminated June 22, 1946; Duty—Springfield, Mass.; Amphibious Training Command; USS Zenobia (Atlantic Fleet).

MONAHAN, DAVID T., Bridgeport; b. 1905; Yale 1933; Army—October 31, 1942 Captain, Major October 1943; Service Terminated February 1, 1946 (Lt. Colonel); Duty—Atlantic City, N. J.; Ft. Sam Houston, Tex.; 5th Auxiliary Surgical Group—Northern France, Ardennes, Western Germany, Central Germany—Ft. Devens, Mass.; Awards—Bronze star; European Theatre of Operation Ribbon w/4 battle stars.

MONTANO, CHARLES C., Hartford; b. 1909; Tufts 1935; P.H.S. (USCG)—April 12, 1943 Senior Asst. Surgeon, Surgeon June 1944, Senior Surgeon September 1945; Service Terminated March 1, 1946; Duty—Miami, Fla., Boston, Mass.

MONTANO, ROCCO A., Hartford.

MOORE, CLIFFORD D., Stamford; b. 1903; Queens 1928; P.H.S.—October 19, 1943 Surgeon (R); Service Terminated October 1, 1944; Duty—Medical Section, War Shipping Administration, New York, N. Y.

MOORE, DONALD B., New Haven.

MOORE, GILBERT E., Darien; b. 1
Yale 1934; Army—August 18, 194
Captain June 1943, Major July
Service Terminated December 22,
Duty—New Guinea; Luzon, P.
Awards—Asiatic-Pacific Theatre Ri
w/2 bronze stars and 1 arrowh
Philippine Liberation Ribbon
bronze star.

MOORE, MAURICE R., Norwich
1900; Queens 1929; Army Air—Oct
19, 1942 Major, Lt. Colonel Januar
1946; Service Terminated March
1946; Duty—Boca Raton, Fla.; Gr
boro, N. C.; Langley Fld., Va.

MORAN, JAMES P., New Londo
1909; Maryland 1936; Navy—May
1941 Lt. (j.g.), Lt. June 15, 1942
Comdr. July 1, 1943, Commander
vember 1, 1945; Service Termin
December 16, 1945; Duty—USS Om
USNR Midshipmans School; USS Br
lyn (Atlantic and Mediterranean T
tres of Operation); (Removed to R
ville Centre, N. Y.).

MORRIS, FELIX R., Stratford; b. 1
Maryland 1941; Army—December
1943 Lt., Captain October 16, 1
Service Terminated December 31, 1
Duty—Carlisle Barracks, Pa.; Beaun
General Hospital; Camp Hood, T
70th Field Hospital (China-Burma-I
Theatre of Operations); USA Dis
sary, Washington, D. C.

MORRIS, JOYCE S., Greenwich.

MORRISSETT, LESLIE E., Greenw
b. 1904; Medical College of Virg
1930; Army—September 30, 1942 Ma
Service Terminated January 28, 1
(Lt. Colonel); Duty—Borden Gen
Hospital, Chickasha, Okla. Office of
Surgeon General, Washington, D.

MOSS, HARRY G., New Haven.

MOTT, FREDERICK E., New Haver
1914; Buffalo 1941; Army Air—Nov
ber 10, 1942 Lt., Captain Octobe
1943; Service Terminated January
1946; Duty—Camp Butner, N. C., Sc
of Aviation Medicine, Randolph
Tex.; Nashville, Tenn.; Kearns, U
Camp Stoneman, Calif.; Flight Surg
Brisbane, Australia; Port Moresby,
G.; Debedure, N. G.; Nadzab. N.
Owi Island; Leyte, P. I.; Awards—Asi
Pacific Theatre Ribbon w/9 battle st
Philippine Liberation Ribbon w/1

XNESS, BENNIE A., Hartford; b.); Georgetown 1925; Army—Febru- 19, 1941 Lt. Colonel, Colonel May 1943; Category I Volunteer; Duty— y Fld., Tex.; Duncan Fld., Tex.; tsville Arsenal, Ala.; Ft. Sheridan, England-Frances (European Thea- of Operations); Camp Crowder, Mo.; Meade, Md.; Italy (Mediterranean atre of Operations); War Dept., hington, D. C. (Regular Army— 1925 to January 1931); (Removed Maryland).

ZZER, ALEXANDER J., Manchest- b. 1912; Hahnemann 1938; Army— 14, 1942 Lt., Captain August 14. ; Service Terminated December 19, ; Duty—East Indies; Papua; New nea; Invasion of Cebu; Philippines iatic-Pacific Theatre of Operations); rds—Purple Heart; Unit Commen- on; Asiatic-Pacific Theatre Ribbon battle stars.

ELLER, OSCAR J., Waterbury.

LAIRE, VICTOR J., Stamford; b. ; Boston University 1939; Army— 1, 1941 Lt., Captain February 1, ; Service Terminated January 16, 5 (Major); Duty—Camp Langdon, H.; 45th Infantry Division—Sicily, y, Southern France, Germany (Medi- anean-Middle Eastern Theatre of rations); Award—Bronze star.

LLIGAN, THOMAS M., Waterbury tered service from Somerville, s.); b. 1912; Boston University 1938; ny—May 7, 1943; Lt., Captain Febru- 1944, Major March 1945; Service minated July 14, 1946 (Lt. Colonel); y—Carlisle Barracks, Pa.; Kennedy eral Hospital, Memphis, Tenn.; 129th eral Hospital—231st Station Hos- l, England—239th General Hospi- Paris, France (European Theatre of rations).

LVILLE, MAURICE F., Hartford.

RCKO, WILLIAM J., Torrington; b. ; Marquette 1937; Army—July 2, 2 Lt., Captain July 29, 1943; Service minated February 4, 1946; Duty— dley Fld., Conn.; Dale Mabrey Field ion Hospital; 870 Avn. Eng. Bn., New nea; 54th Evacuation Hospital, Leyte- on, P. I. (Asiatic-Pacific Theatre of rations).

RPHY, CHARLES A., Stamford; b. ; Long Island College of Medicine ; Navy—April 26, 1943 Lt., Lt. Comdr. October 1945; Service Terminated January 5, 1946; Duty—Sub. Base, New London, Conn.; Falmouth, England; (European Theatre of Operations); Quonset Point, R. I.; Providence, R. I.; Award—Letter of Commendation.

MURPHY, JOHN J., East Hartford.

MURPHY, THOMAS B., Wallingford; b. 1897; Harvard 1923; Navy—November 16, 1944 Lt. Comdr.; Service Terminated April 4, 1946; Duty—Chelsea, Mass.; San Bruno, Calif.; Naval Hospital #3864, Manicani Island, P. I. (Asiatic-Pacific Theatre of Operations).

MURPHY, THOMAS D., Simsbury.

MURPHY, THOMAS F., West Hartford; b. 1907; Jefferson 1933; P.H.S. (USCG)—February 1, 1943 Lt., Lt. Comdr. July 3, 1944; Service Terminated December 26, 1945; Duty—Norfolk, Va.; Portsmouth, Va.; Boston, Mass.

NAROWSKI, JOHN J., Derby; b. 1917; Tufts 1943; Army—January 14, 1944 Lt., Captain June 1, 1945; Service Terminated August 24, 1946; Duty—Carlisle Barracks, Pa.; Thayer General Hospital, Tenn.; Lawson General Hospital, Ga.; 78th Field Hospital—160th General Hospital—136th Evacuation Hospital—235th General Hospital—41st Engr. GS.; 117th Evacuation Hospital, 124th General Hospital (European Theatre of Operations); Awards—European African Middle Eastern Campaign medal w/1 battle star.

NEFF, WILLIAM E., JR., Cheshire; b. 1907; Columbia 1933; Navy—June 9, 1941 Lt. (j.g.), Lt. January 1, 1942, Lt. Comdr. May 1, 1943, Camdr. November 1, 1945; Service Terminated November 13, 1945; Duty—Venereal Disease Control—Chemical Warfare School—Australia; Western Samoa; Guadalcanal; Melbourne, Australia; Goodenough Island; Finchhaven, N. G.; Cape Gloucester, N. B. (Asiatic-Pacific Theatre of Operations); Award—Unit Presidential Citation.

NEIDLINGER, WILLIAM J., Hartford; b. 1907; Cornell 1933; Army—June 30, 1943 Lt., Captain May 1944, Major May 1946; Service Terminated August 12, 1946; Duty—Atlanta, Ga.; Thomasville, Ga.; Ft. McClellan, Ala.

NELSON, ROGER B., Waterbury; b. 1908; Cornell 1934; Navy—January 4, 1943 Lt., Lt. Comdr. October 3, 1945; Service Terminated May 29, 1946; Duty—Brooklyn, N. Y.; Long Beach, L. I., N. Y.; Banana River, Fla.; Ft. Pierce, Fla.; Washington, D. C.; Anacostia, D. C.; (Removed to New York).

NESBITT, SAMUEL, New Haven (Removed).

NESPOR, ROBERT W., Westport; b. 1906; Boston University 1933; Navy—December 23, 1941 Lt. (j.g.), Lt. June 1942, Lt. Comdr. March 1944; Service Terminated November 24, 1945; Duty—Albany, N. Y.; Buffalo, N. Y.; New Haven, Conn.; Norfolk, Va.; LST Group Staff 47 (Asiatic-Pacific Theatre of Operations).

NEVULIS, ANTHONY V., New Britain; b. 1908; Vermont 1938; Army—April 21, 1941 Lt., Captain August 1943, Major March 1945; Service Terminated November 17, 1945; Duty—Ft. Banks, Mass.; Ft. Devens, Mass.; 208th General Hospital, Iceland; 327th Station Hospital, England and France (European-African-Middle Eastern Theatre of Operations).

NEWMAN, HARRY R., New Haven (Entered service from New York, N. Y.); b. 1909; Toronto 1935; Army—September 11, 1942 Captain, Major January 6, 1945; Service Terminated March 6, 1946; Duty—Miami, Fla.; Tampa, Fla.; Hunter Fld, Ga.

NEWMAN, RICHARD, New Haven; b. 1905; Johns Hopkins 1930; Navy—March 20, 1944 Lt. Comdr.; Service Terminated May 15, 1946; Duty—Bethesda, Md.; Portsmouth, Va.

NICHOLS, EDWARD, Hartford; b. 1911; Yale 1938; Army—April 23, 1942 Captain, Major October 26, 1945; Service Terminated February 1946; Duty—Asiatic-Pacific Theatre of Operations; China-Burma-India Theatre of Operations.

NICHOLS, FREDERICK L., Hartford.

NIELSEN, TAGE M., New London (Entered service from Copenhagen, Denmark); b. 1910; Copenhagen (Denmark) 1938; Danish Navy—February 1942 (USCG); Service Terminated May 1, 1945; Duty—Ship's Surgeon—Training Ship "Danmark"—U. S. Coast Guard Academy, New London, Conn.

NOBLE, ROBERT P., Sharon (Entered service from Riverdale, N. Y.); b. 1913; Columbia 1940; Navy—April 1945 Lt. (j.g.); Service Terminated August 17, 1946; Duty—USS Consolation (Asiatic-Pacific Theatre of Operations).

NODELMAN, JACOB, New Haven; b. 1904; Yale 1929; Navy—February 1943 Lt. Comdr., Service Terminated December 22, 1945; Duty—Sampson, N. Y.; Receiving Ship, Pier 92, N. Y., N. Y.; Brooklyn, N. Y.; USS Fond du Lac (Asiatic-Pacific Theatre of Operations); Naval Communications School, Los Angeles, Calif.; Acorn Unit No. 52, G-8, Compt. 34; Oceanside, Calif.; Camp Pendleton, Calif.

NORTHMAN, FRANK F., Bridgeport (Entered service from Hudson Falls, N. Y.); b. 1907; Breslau (Germany) 1934; Army—September 10, 1942 Lt., Captain November 23, 1943; Service Terminated May 18, 1946; Duty—Lordsburg, N. M.; Camp Claiborne, La.; Camp Chaffee, Ark.; Ft. Sam Houston, Tex.

O'BRASKY, GEORGE H., New Haven; b. 1894; Jefferson 1920; Army—February 24, 1941 Lt. Colonel, Colonel August 16, 1946; Service Terminated December 9, 1946; Duty—Camp Blanding, Fla.; Camp Shelby, Miss.; New Orleans, La.; Washington, D. C.; Camp Edwards, Mass.; Hqs.—1st Service Command, Boston, Mass.

O'BRIEN, HENRY R., Hartford.

O'CONNELL, WILLIAM M., West Haven; b. 1892; Yale 1917; Navy—December 28, 1944 Lt. Comdr.; Service Terminated December 28, 1945; Duty—Sub. Base, New London, Conn.

O'CONNOR, DENIS S., New Haven; b. 1893; Bowdoin 1919; Navy—December 17, 1941 Lt. Comdr., Commander October 1942, Captain March 1945; Service Terminated March 27, 1946; Duty—Recruiting Office, New Haven, Conn.; Mobile Hosp. #4 (Asiatic-Pacific Theatre of Operations); Naval Hospital, Sampson, N. Y.

OGILVIE, JOHN B., Stamford (Entered service from New York City); b. 1910; Yale 1934; Army—July 15, 1942 Captain, Major November 15, 1944; Service Terminated February 19, 1946; Duty—Ft. Andrews, Mass.; 9th General Hospital—Brisbane, Australia, Goodenough Island, Biak, N.E.I.;—Manila, Luzon, P. I. (Asiatic-Pacific Theatre of Operations); Award—Meritorious Service Unit Award.

O'MEARA, FRANCIS P., Glenbrook; b. 1907; New York Medical College 1936; Navy—June 10, 1942 Lt., Lt. Comdr. July 10, 1945; Service Terminated December 27, 1945; Duty—Brooklyn, N. Y.; Philadelphia, Pa.; Sub. Base, New London, Conn.; USS Chewink—USS Tryon (Asiatic-Pacific Theatre of Operations).

O'NEIL, VINCENT D., Newington; b. 1915; McGill 1941; Army—July 5, 1942 Lt., Captain January 28, 1943; Service Terminated January 20, 1946; Duty—2nd Infantry Division, Camp Grant, Ill.; Ft. Sam Houston, Tex.; Camp McCoy, Wisc.; Ireland-Wales-Normandy-France-Belgium - Germany - Czechoslovakia; Awards—Bronze star; European Theatre Ribbon w/5 battle stars.

ORLOWSKI, ANDREW W., Torrington; b. 1907; Tufts 1936; Navy—May 6, 1942 Lt. (j.g.), Lt. March 1943, Lt. Comdr. October 1945; Service Terminated June 30, 1946; Duty—Portsmouth, Va.; USS Borie—USS Barry—Washington, D. C.; Bethesda, Md.; Blood Donor Service—Hartford, Conn., New York, N. Y.; Charleston, S. C.

OTTENHEIMER, EDWARD J., Willimantic; b. 1898; Virginia 1922; Army—July 15, 1942 Major, Lt. Colonel September 17, 1943; Service Terminated October 23, 1945 (Colonel); Duty—39th General Hospital, Auckland, N. Z.; Hdq. South Pacific, Numea, New Caledonia; Hdq. Pacific Ocean Areas, Honolulu, T. H.; 148th General Hospital, Saipan, M. I.; Hdq., Western Pacific, Saipan, M. I.; (Asiatic-Pacific Theatre of Operations); Awards—Bronze star w/oak leaf cluster.

OUGHTERSON, ASHLEY W., New Haven; b. 1895; Harvard 1924; Army—January 28, 1942 Lt. Colonel, Colonel December 11, 1943; Service Terminated August 6, 1946; Duty—Army Medical Center, Washington, D. C.; Lovell General Hospital, Ft. Devens, Mass.; 39th General Hospital—Consultant in Surgery, Hdq. South Pacific-Pacific Ocean Area; G.H.J. Pacific Armed Forces; Chairman, Joint Committee for Investigating Effects Atomic Bomb in Japan (Asiatic-Pacific Theatre of Operations); Awards—Legion of Merit; Legion of Merit w/oak leaf cluster.

OWENS, ANDREW P., Brdigeport; b. 1916; McGill 1942; Army Air—September 24, 1943; Lt., Captain June 6, 1945; Service Terminated July 13, 1946; Duty—Carlisle Barracks, Pa.; School of Aviation Medicine, Randolph Fld., Tex.; School of Applied Tactics, Orlando, Fla.; Kearney, Neb.; Pratt, Kans.; Fair[illegible] Suisan, Calif.

PADULA, VINCENT D., Hartfor[illegible] 1904; Rome (Italy) 1935; Army—[illegible] 23, 1943 Captain; Service Termi[illegible] January 29, 1945; Duty—Contin[illegible] United States.

PAGLIARO, JOSEPH J., Shelto[illegible] 1912; Georgetown 1937; Army [illegible] December 15, 1940 Lt., Captain F[illegible] ary 1, 1942, Major November 5, [illegible] Lt. Colonel June 15, 1944; Service [illegible] minated January 15, 1946; Duty—F[illegible] Surgeon (North African-Mediter[illegible] Theatres of Operation); Awards—[illegible] Pearl Harbor Ribbon; European Th[illegible] Ribbon w/4 battle stars.

PALEY, I. MARTIN, Stamford.

PANETTIERI, ANDREW J., Br[illegible] port; 2. 1913; Vermont 1937; Army[illegible] —November 19, 1943 Lt., Captain [illegible] ust 19, 1944; Service Terminated J[illegible] ary 30, 1946; Duty—Salt Lake [illegible] Utah; McCook Fld., Nebr.; Casper, W[illegible] First Air Commando Group (As[illegible] Pacific and China-Burma-India The[illegible] of Operations); Awards—3 battle [illegible]

PAPA, JOHN S., Bristol; b. 1902; T[illegible] 1928; Navy—October 25, 1943 [illegible] Comdr., Commander November 5, 1[illegible] Service Terminated April 28, 1[illegible] Duty—Sub. Base, New London, C[illegible] Chemical Warfare School, Edgew[illegible] Arsenal, Md.; Sub. Chaser Training [illegible] ter, Miami, Fla.; USS Allendale; [illegible] CB's—Guam; Eniwetok (Asiatic-Pa[illegible] Theatre of Operations); Sampson, N[illegible]

PARLATO, HARRY A., New Britai[illegible] 1910; New York University 1936; A[illegible] —October 1944 Lt.; Service Termin[illegible] May 22, 1945; Duty—U. S. Veterans [illegible] ministration, Coatesville, Pa.

PARRELLA, GIOACCHINO S., N[illegible] ington; b. 1917; Yale 1941; Army—[illegible] 8, 1944 Lt., Captain April 15, 1[illegible] Service Terminated September 25, 1[illegible] Duty—Camp Bowie, Tex.; Engl[illegible] France -B elgium - Germany (Euro[illegible] Theatre of Operations); Ft. Jack[illegible] S. C.; Framingham, Mass.

PARSHLEY, PHILIP F., West Hartf[illegible] b. 1902; Pennsylvania 1927; Na[illegible] March 22, 1943 Lt. Comdr., Comma[illegible] November 1945; Service Termin[illegible] March 10, 1946; Duty—Norfolk, [illegible] Asiatic-Pacific Theatre of Operati[illegible] Brooklyn, N. Y.

TTO, EDO E., Waterbury; b. 1910; ıont 1936; Army—September 5, Captain, Major 1944; Service Ter- ted June 5, 1945; Duty—Asiatic- c Theatre of Operations.

TERNAK, MAXWELL, New n; b. 1907; Toronto 1936; Army Air gust 31, 1943 Lt., Captain October Service Terminated December 12, (Major); Duty—Keesler Fld., ; School of Aviation Medicine, olph Fld., Tex.; Gowen Fld., Idaho; ilton Fld., Calif.

TERSON, FREDERICK A., South valk; b. 1899; Harvard 1927; Army y 16, 1943 Captain, Major Novem- , 1945; Service Terminated Decem- , 1945; Duty—Camp Croft, S. C.; Bragg, N. C.—114th General Hos- England—81st General Hospital, s-France (European Theatre of Op- ıns).

COCK, ALBERT U., Hartford; b. Rush 1933; Navy—July 5, 1943 t. Comdr. October 1, 1945; Service ıinated May 2, 1946; Duty—New- R. I.; Third Marine Aircraft Wing ıtic-Pacific Theatre of Operations); Base, New London, Conn.

Z, WILLIAM L. (Removed to delphia, Pa.).

., KURT S., Wallingford; b. 1905; na (Austria) 1931; Army—Febru- 6, 1943 Lt., Captain September 27, Service Terminated November 7, (Major); Duty—Carlisle Barracks, Camp Stewart, Ga.; Richmond, Va.; pean Theatre of Operations; ds—Bronze star; Citation, Gen. gomery, Belgian Government.

NER, SIDNEY L., Stratford; b. Columbia 1934; Army—May 6, Lt., Captain 1945; Service Termi- May 6, 1947; Duty—Carlisle Bar- , Pa.; New Orleans, La.; Ft. Ben- Ga.; Ft. Bragg, N. C.; Phoenix- Pa.

, ANTHONY J., Norwich; b. 1910; land 1935; Army—September 2, Lt., Captain March 1944; Service ıinated March 2, 1946; Duty—West- Fld., Mass.; Miami Beach, Fla.; ns Fld., Ga.; Charleston, S. C;. more, Md.; Air Intelligence School, isburg, Pa.; Greensboro, N. C.; h African-Mediterranean Theatre of ations; McCord Fld., Wash.; Geiger Fld., Wash.; Awards—European-African-Middle Eastern Theatre Ribbon w/2 battle stars.

PERAKOS, GEORGE P., New Britain; b. 1907; Georgetown 1937; Army—January 28, 1944 Lt., Captain 1945; Service Terminated July 1946; Duty—Newton D. Baker Hospital, Martinsburg, W. Va.; Award—Army Commendation Ribbon.

PERHAM, WILLIAM S., New Haven; b. 1905; Michigan 1932; Army—June 25, 1942 Captain, Major February 18, 1943, Lt. Colonel December 1945; Service Terminated Januar 13, 1946; Duty—39th General Hospital, Auckland, N. Z.; 148th General Hospital, Saipan, M. I. (Asiatic-Pacific Theatre of Operations); Awards—Bronze star; Certificate of Commendation.

PERKINS, JOSEPH A., Hartford.

PHILLIPS, HARRY S., Westport; b. 1895; Toronto 1922; Army—May 25, 1942 Captain Major February 18, 1943; Service Terminated February 2, 1946; Duty—Tenth Field Hospital—Tunisia, Sicily, Italy (North African-Mediterranean Theatre of Operations); School of Military and Tropical Medicine; Camp Shelby, Miss.; New Guinea; Philippines (Asiatic-Pacific Theatre of Operations); Award—Unit Citation.

PHILLIPS, NICHOLAS T., Norwich; b. 1918; Boston University 1944; Navy—June 1945 Lt. (j.g.) (Marine Corps); Service Terminated August 16, 1946; Duty—Boston, Mass.; Ft. Eustis, Va.; Bainbrdige, Md.; Camp Lejeune, N. C.; (AUS) May 1943-September 1944).

PICCOLO, PASQUALE A., New Haven; b. 1912; Maryland 1937; Army Air—May 16, 1942 Lt., Captain December 18, 1942, Major January 28, 1944; Service Terminated December 7, 1945; Duty—Letterman General Hospital, San Francisco, Calif.; School of Aviation Medicine; Flight Surgeon, Hawaii; Christmas Island; New Hebrides; Guadalcanal; Bougainville; Dutch New Guinea (Asiatic-Pacific Theatre of Operations); School of Aviation Psychiatry, Ft. Logan, Colo.; Awards—Letters of Commendation.

PIERCE, HAROLD F., West Hartford (Entered service from New York City); b. 1889; Johns Hopkins 1935; Army Air—July 23, 1942 Major, Lt. Colonel January 11, 1947; Service Terminated March 12, 1947; Duty—Chief of Medical Service and Flight Surgeon, Randolph Field Sta. Hospital, Tex.; Flight Surgeon Consultant, Brooke General Hospital, Fort Sam Houston, Tex.; Surgeon, Old Farms Convalescent Hospital, Avon, Conn.; Medical Officer, Veterans Administration, Massachusetts and Connecticut, and Tilton General Hospital, Fort Dix, N. J.

PIKE, MAURICE M., Hartford; b. 1900; Harvard 1925; Army—October 22, 1943 Major, Lt. Colonel September 1945; Service Termianted August 27, 1946; Duty—Carlisle Barracks, Pa.; Dibble General Hospital, Menlo Park, Calif.; Award—Army Commendation Ribbon.

PILECKI, PETER J., Middletown; b. 1917; Loyola 1943; Navy—October 1944 Lt. (j.g.); Service Terminated June 20, 1946; Duty—Newport, Ark.; Treasure Island, Calif.; USS Bristol; USS Cecil (Asiatic-Pacific Theatre of Operations); Columbus, Ohio; Great Lakes, Ill.; Award—Third Fleet Citation.

PINN, ABRAHAM S., New Haven; b. 1902; Laval 1929; Army—August 21, 1942 Captain, Major May 29, 1943; Service Terminated January 18, 1946 (Lt. Colonel); Duty—Continental United States (European Theatre of Operations); Award—Unit Citation.

PITOCK, MORRIS P., Bridgeport; b. 1902; Tufts 1930; Army Air—May 14, 1942 Major; Service Terminated December 26, 1945; Duty—North African-Mediterranean Theatre of Operations; Flight Surgeons Course, Randolph Fld., Tex.; Continental United States.

PLATT, JOHN W., Mystic.

POCZABUT, JOHN S., Stamford (Entered service from Florence, Vermont); b. 1914; Vermont 1941; Army—July 1, 1942 Lt., Captain August 25, 1943; Service Terminated December 29, 1945 (Major); Duty—16th Med. Regt.; 261st Med. Batallion; 174 General Hospital; 280th Station Hospital, 119th Evacuation Hospital (North African-Mediterranean-Europen Theatres of Operations); Awards—Bronze Arrowhead; Presidential Unit Citation; 7 battle stars; Croix de Guerre w/palm.

POIRIER, THEODORE M., Windsor.

To be Continued

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Charles W. Goff, West Hartford
President-elect, Mrs. Ralph L. Gilman, Storrs
First Vice-President, Mrs. F. Erwin Tracy, Middletown
Second Vice-President, Mrs. Charles H. Sprague, Bridgepo
Recording Secretary, Mrs. Paul Vestal, Woodbridge
Treasurer, Mrs. Frank DiStasio, New Haven
Corresponding Secretary, Mrs. J. Whitfield Larrabee, West Hartford

The Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society held a meeting in June at the New Haven Medical Society Building. Plans were made for the fall meeting and various matters concerning legislature were discussed and clarified. Names were submitted for a chairman for the Nurse Recruitment Project, and Mrs. Charles Goff our president said that she hoped by the fall each of the counties would have a chairman appointed for this office so that work of this very important project might begin as soon as possible. After lunch the State Standing Committee chairmen met with their County chairmen and plans were made for carrying out the work for the coming year.

We are looking forward to the first issue of the new publication, *The Bulletin of the Woman's Auxiliary to the Connecticut State Medical Society*, which will be mailed to all the members of the Connecticut State Auxiliary. Mrs. Paul Phelps, chairman of the Editorial Board, has stated that it will feature special articles on health news, comments on legislation directly or indirectly affecting members of the medical profession, county news, reviews of books of particular interest to doctors' wives, and other news of current interest. In addition to Mrs. Phelps, the chairman, the Editorial Board consists of Mrs. Edward R. Smith of Meriden, editor; Mrs. Robert J. Cook of New Haven, Mrs. Joseph H. Howard of Bridgeport, Mrs. Harry F. Pennington of Meriden, Dr. Creighton Barker of New Haven, medical advisor, and Dr. Stanley B. Weld of Hartford, honorary member, Mrs. Gardiner Russell of West Hartford, ex officio, and Mrs. Lyman R. Morse of Wethersfield. Local and county news will be reported by the following: Mrs. Nicholas Creaturo, Fairfield county; Mrs. Andrew Taylor, Hartford county; Mrs. Clifford Conklin, Litchfield county; Mrs. Joseph O. Collins, New Haven county; Mrs. Harry C. Knight, Middlesex county; and Mrs. John Brosnan, New Londo county.

Mrs. James Raglan Miller, member of the Nation al Committee on Organization, reports that Woman's Auxiliary to the Massachusetts Medica Society has been fully organized. Officers elected a the annual meeting, May 26, 1948, were Mrs. Leigh ton F. Johnson, Brookline, president; Mrs. E. C Ayres, Worcester, vice-president; Mrs. J. F. Conlir Boston, secretary; Mrs. Leo G. Rondeau, Brightor treasurer. Five Woman's Auxiliaries to district medi cal societies were formed with total membership o 608. Additional 9 district medical societies have ap proved the formation of auxiliaries. Thus in earl fall 14 out of 18 districts will be organized. We con gratulate our neighbors and wish them success.

Early in spring a great need of clothing among th wives of physicians in England has been brought t the attention of the State Board of Directors b Mrs. James Raglan Miller. Through her persona contact with Mrs. Guy Dain, wife of the chairma of the Council of the British Medical Association Mrs. Miller received the name of a physician's wif to whom she sent a trial package with better use clothing. The appreciation expressed by the receiv ers was very gratifying. Though a small duty an tax charge had to be paid, the clothes were dis tributed among several physicians' families, makin the cost very reasonable. Packages with food wer also sent and received with great enthusiasm. Th State Auxiliary is very interested in this project an hopes that most of the counties will participate i it. The Hartford County has already voted to do so The rationing of clothes for adults in England ha apparently created a great hardship to obtain them

HARTFORD COUNTY

The June activities of the Hartford County Asso ciation consisted of two events. The annual lunch eon bridge was held on June 8 at the Tumblebrook

Country Club, Bloomfield; Mrs. Edmund Beizer, hospitality chairman, made arrangements and a delicious luncheon was served followed by bridge. Over seventy members attended.

A meeting of the executive board was held on June 10 and plans for the year's activities were discussed. In addition to the Rummage Sale and Spring Concert, it was voted to hold a Bazaar in December to raise additional money for the Memorial Scholarship Fund. This fund is in the greatest need as it was so recently established and there have already been many applications for financial assistance from prospective nurses and medical students.

WINDHAM COUNTY

An executive meeting was held in May to discuss plans for next winter. The feeling of the meeting was that this group is equally interested in two projects: (1) health survey of the community, (2) nurse recruitment. It was decided to have each of these subjects presented at the meetings and Mrs. Kinney, the program chairman, will arrange for speakers. Plans were also made to continue the collection of magazine and Chrsitmas gifts for the mental hospitals.

A Smorgasbord was held in Putnam and 32 doctors and their wives were present at this purely social and pleasant occasion.

EDITORIAL BOARD MEETING

The meeting of the Editorial Board was held at the New Haven Medical Society Building on June 15 and was called to order by the chairman, Mrs. Paul S. Phelps. The following members were present: Mesdames Edward Smith, Robert Cook, G. Gardiner Russell, Paul Phelps. Mr. James Burch represented Dr. Creighton Barker who was unable to be present.

Mrs. Edward R. Smith, editor, presented samples of the type of material and manner in which it will be published in the *Bulletin*. The members were much impressed.

A motion was made by Mrs. Cook, seconded and carried, that a supply of envelopes for the year be purchased.

Mrs. G. Gardiner Russell was asked to forward to Mrs. Smith by September 1 the names and correct manner of addressing our senators and congressmen. This information is to be issued in the first and second editions of the *Bulletin*.

The next meeting of the Editorial Board will be held on September 2. This will be a most important meeting as all material must be reviewed and passed on for publication at this time.

At the conclusion of the Board meeting there was a discussion with the editors of the counties. Mrs. Smith presented each editor with a typewritten copy with instructions as to the handling and the type of material suitable for publication—local news items, speaker's bureau, anecdotes from a doctor's life, typing, also do's and don'ts. The Board was very pleased to have Mr. James G. Burch present. He gave us splendid suggestions and was most encouraging.

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Mrs. Robert H. Campbell, 55 North Main
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Mrs. James Carroll, 250 Griswold Dr.
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Mrs. Gilbert W. Heublein, 77 Crestwood Rd.
Mrs. Otto M. Hirschfelt, 282 Fern
Mrs. Walter L. Hogan, 68 Rumford Rd.
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Mrs. H. G. Jarvis, 40 Ledyard Rd.
Mrs. Frank S. Jones, 7 Ten Acre Lane
Mrs. George Keefe, 17 Walbridge Rd.
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Mrs. Milton F. Little, 38 Walbridge Rd.
Mrs. Harry L. F. Locke, 39 Robin Rd.
Mrs. Thomas J. Luby, 14 Bainbridge Rd.
Mrs. Francis L. Lundborg, 35 North Main
Mrs. Morris M. Mancoll, 285 North Quaker Lane
Mrs. John Martin, 3 Arlington Rd.
Mrs. Stevens Martin, 1240 Asylum Ave.
Mrs. John J. McLean, 17 Concord
Mrs. Seymour Miller, 390 Fern
Mrs. Charles Montano, 83 Van Buren Ave.
Mrs. Thomas F. Murphy, 30 Blue Ridge
Mrs. William Neidlinger, 15 Staples Pl.
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Mrs. John D. O'Connell, 8 Fairlee Rd.
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Mrs. J. G. M. Olmsted, 24 Westwood Rd.
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Mrs. Robert H. Osmond, 29 Cornell Rd.
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Mrs. Phillip F. Parshley, 319 North Quaker Lane
Mrs. Winthrop Partridge, 129 Ridgewood Rd.
Mrs. A. U. Peacock, 36 Four Mile Rd.
Mrs. Harold T. Pierce, 156 Raymond Rd.
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Mrs. Thomas R. Preston, 133 North Quaker Lane
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Mrs. John Sayers, 573 Park Rd.

Mrs. Peter Scafarello, 60 Arnoldale Rd.
Mrs. William Scoville, 334 North Steele Rd.
Mrs. Sydney Sewall, 351 Ridgewood Rd.
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Mrs. Daniel Samson, 147 Elm
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Mrs. Frank Reichenback, 228 Cutler

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Mrs. Chester English, 88 Wheeler
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Mrs. Francis J. Gallo, 384 Main
Mrs. Donald W. Herman, 42 Walnut

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Mrs. William Joyce, 92 Main
Mrs. Walter H. Nelson, 76 Main

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Mrs. Henry Sherwood, Main

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Mrs. Louis Soreff, 15 Main

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Mrs. Fred Bradeen, Box 221

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Mrs. Hazen Calhoun
Mrs. C. Mansfield Craig

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Mrs. Clair Crampton, 158 Mt. Vernon
Mrs. Harry S. Frank, 230 Washington
Mrs. Julius Grower, 32 Mansfield Ter.
Mrs. Carl C. Harvey, 20 Silver
Mrs. Sanford Harvey, 47 Deerfield Ave., R. F. D. No. 2
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Mrs. Louis Loffredo, 77 Crescent
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Mrs. Lloyd Minor, 495 Ridge Rd.
Mrs. Mario Palmieri, 54 Broad
Mrs. Peter F. Piasta, 145 South Main
Mrs. Abraham Rafkind, 217 South Main
Mrs. Ben. Roccapriore, 287 Washington Ter.
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Mrs. Benjamin Shenker, 57 South Main
Mrs. Benjamin Simon, Connecticut State Hospital
Mrs. Harold Speight, 417 High
Mrs. Charles Sutch, Connecticut State Hospital
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Mrs. Mark Thumim, 57 South Main
Mrs. F. Erwin Tracy, Old Mill Rd.
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Mrs. William Wrang, 8 Mazzotta Pl.
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Mrs. Thomas Horsefield

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Mrs. Joseph Epstein, 311 Main
Mrs. Americo Longo, 344 Main
Mrs. Hamilton Rinde, 230 Main
Mrs. Philip Schwartz, 309 Main
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Mrs. George Levak, 25 Church
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Mrs. Samuel B. Rentsch, 61 Seymour Ave.
Mrs. Maxon M. Senfield, 238 Hawthorne

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Mrs. Louis N. Claiborn, 64 Blake Rd.
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Mrs. Charles Culotta, 99 Glenbrook Ave.
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Mrs. Stephen Lirot, 17 Windsor Ave.
Mrs. Walter Lohrmann, Undercliff
Mrs. Joseph Mekrut, 569 East Main
Mrs. Bernard Mills, 94 East Main
Mrs. Joseph F. Misuk, 16 Collins Pkwy.
Mrs. Thomas Murdock, 19 Windsor Ave.
Mrs. Fessenden N. Otis, 115 Winthrop Ter.
Mrs. Harry Pennington, 119 Williams
Mrs. Rocco J. Petrucelli, 155 Main, South Meriden
Mrs. Louis Pierson, 130 Bradley Ave.
Mrs. Raymond Quinlan, 36 Winthrop Ter.
Mrs. Samuel Robb, Terrace Gardens
Mrs. Allan J. Ryan, 63 Bellevue
Mrs. Peter Skladzien, 600 Broad
Mrs. Edward R. Smith, Coe Ave.
Mrs. Harold Strickland, 128 Main
Mrs. L. E. Thompson, Undercliff
Mrs. Arthur Tower, 173 Curtis
Mrs. James S. VanLeuvan, 62 Hillcrest Ter.
Mrs. J. Alfred Wilson, 128 Curtis

MIDDLEBURY

Mrs. John Foster, Porter Hill
Mrs. A. A. Johnson, Crest Rd.
Mrs. Alfred Reichenback, Watertown Rd.
Mrs. Jasper A. Smith. Central Rd.

MILFORD

Mrs. Walter E. Barney, 186 Broad
Mrs. William J. J. Fischer, 13 Lafayette
Mrs. John R. Lee, 21 Colonial
Mrs. Frank Lee, 56 Broad
Mrs. Clarence Lipkoff. 7 River
Mrs. Benjamin Rosenthal, 26 Lafayette
Mrs. Harry Stetson, Robert Treat Pkwy.

NAUGATUCK

Mrs. D. H. Bluestone, 9 Terrace Ave.
Mrs. William E. Hill, 150 Meadow
Mrs. Leo Tylec, 156 Meadow

NEW HAVEN

Mrs. Irving S. Alderman, 2110 Chapel
Mrs. Edward P. Allen, 147 Alden Ave.
Mrs. Millard F. Allen, 65 Dixwell Ave.
Mrs. Ralph D. Alley, 76 Everit
Mrs. Creighton Barker, 119 Armory
Mrs. Charles J. Bartlett, 183 Bishop
Mrs. Anthony W. Battista, 111 Osborn Ave.
Mrs. Edmund J. Behan, 2015 Chapel
Mrs. Benedict Biondi, 120 Blatchley Ave.
Mrs. Francis G. Blake, 389 St. Ronan
Mrs. Joseph Bruno, 505 Whalley Ave.
Mrs. Alfonso Capecelatro, 142 Columbus Ave.
Mrs. Samuel Climo, 25 Woodside Dr.
Mrs. William F. Collins, 181 Howard Ave.
Mrs. Mario Conte, 774 Townsend Ave.
Mrs. Robert Cook, 651 Prospect
Mrs. A. Nowell Creadick, 77 Loomis Pl.
Mrs. Eduard C. Curne, Jr., 154 Alston Ave.
Mrs. Harry L. Day, 1076 Forest Rd.
Mrs. Arthur Dayton, 61 Loomis Pl.
Mrs. Charles K. Deming, 244 Bradley
Mrs. William J. Dennehy, 600 Prospect
Mrs. Frank DiStasio, 251 Edwards
Mrs. Simon Doff, 195 Willard
Mrs. Joseph H. Evans, 1488 Chapel
Mrs. Peter Fiskio, 307 Humphrey
Mrs. Harold Flynn, 464 Dixwell Ave.
Mrs. Barnett Freedman, 322 George

Mrs. Mario L. Garofalo, 818 Townsend Ave.
Mrs. Angelo Gentile, 155 Upson Ter.
Mrs. James Gettings, 256 McKinley Ave.
Mrs. Reginald Gillson, 618 Whitney Ave.
Mrs. Roy J. Gilmer, 259 Dixwell Ave.
Mrs. Samuel Goldberg, Sr., 508 Yale Ave.
Mrs. Morris Goldstein, 451 George
Mrs. Barnett Greenhouse, 1687 Boulevard
Mrs. Morris A. Hankin, 1620 Boulevard
Mrs. James C. Hart, 820 Elm
Mrs. Samuel Harvey, 211 Highland
Mrs. Clayton Hitchins, 599 Whitney Ave.
Mrs. Charles H. Hodgkins, Jr., 831 Elm
Mrs. Samuel D. Kushlan, 655 Whitney Ave.
Mrs. Maxwell Lear, 1172 Chapel
Mrs. Hyman Levin, 168 Linden
Mrs. Daniel Levy, 81 McKinley Ave.
Mrs. Robert Lewis, 52 Trumbull
Mrs. Gustaf Lindskog, 50 Marvel Rd.
Mrs. William Logan, 2000 Chapel
Mrs. Robert M. Lowman, 108 Livingston
Mrs. Carter Marshall, 215 Lakeview Ter.
Mrs. Harry A. Maynard, 882 Howard Ave.
Mrs. William Mendelsohn, 170 Linden
Mrs. Frank Mongillo, 20 Elmwood Rd.
Mrs. Donald Moore, 588 Howard Ave.
Mrs. Kenneth R. Morgan, 168 Prospect
Mrs. Harry G. Moss, 646 Dixwell Ave.
Mrs. Luther Musselman, 192 Livingston
Mrs. Ralph Nichols, 62 West Rock Ave.
Mrs. Louis O'Brasky, 530 Ellsworth Ave.
Mrs. Denis O'Connor, 394 Central Ave.
Mrs. Joseph Petrelli, 157 East Rock Rd.
Mrs. Samuel Philipson, 665 Ellsworth Ave.
Mrs. David Poverman, 67 Trumbull
Mrs. Grover F. Powers, 167 Armory
Mrs. Walter Russell, 139 Alston Ave.
Mrs. Marvin M. Scarbrough, 47 Trumbull
Mrs. Robert Seabury, 58 Trumbull
Mrs. Leo Shay, 354 Alden Ave.
Mrs. Michael Shea, 500 Howard Ave.
Mrs. Harris B. Shumacker, Jr., 390 Livingston
Mrs. Samuel J. Silverberg, 140 Laurel Rd.
Mrs. Morris R. Slater, 68 Norton
Mrs. William Stetson, 646 Dixwell Ave.
Mrs. Harry Stewart, 35 Pendleton
Mrs. Maurice Strauss, 18 Everit
Mrs. Herbert Thoms, 272 Edgehill Rd.
Mrs. Wilder Tileston, 15 Edgehill Rd.
Mrs. Frank E. Toole, 90 Alden Ave.
Mrs. Michael Vegliante, 174 Bradley
Mrs. Edward Wakeman, 181 Edwards
Mrs. Arthur Weil, 670 Prospect
Mrs. Sidney Winters, 170 McKinley Ave.
Mrs. John C. Yavis, 115 Dwight

NORTHFORD

Mrs. R. E. McDonnell

NORTH HAVEN

Mrs. Eugene M. Blake
Mrs. Orvan Hess, Old Orchard Rd.
Mrs. Irvin Shaffer, Hartford Tpke.

ORANGE

Mrs. Melchoir Savarese, Box 260, Derby Ave.

SEYMOUR

Mrs. William Harrison, Great Hill Rd.
Mrs. Oscar Rogol, 128 North

WALLINGFORD

Mrs. William Boyd, 176 North Main
Mrs. John C. Carrozzella, 35 South Main
Mrs. J. T. Fergerson, 188 Main
Mrs. Frank Konopka, 6 South Whittlesey Ave.
Mrs. W. Haviland Morriss, Gaylord Farms
Mrs. Thomas Murphy, 324 Elm
Mrs. Siegmund Pelz, 26 South Main
Mrs. Mark T. Sheehan, 245 Center
Mrs. John Spignesi, 397 North Main

WATERBURY

Mrs. H. Everett Allen, 210 Woodlawn Ter.
Mrs. Charles H. Audet, 42 Church
Mrs. Louis Backhus, 79 Greenleaf Ave.
Mrs. Walter L. Barber, Jr., 102 Euclid Ave.
Mrs. Theodore F. Bevans, 165 Fiske
Mrs. Orpheus J. Bizzozero, Country Club Rd.
Mrs. Rudalf Blau, 47 Cook
Mrs. Maxwell H. Bloomberg, 197 Lincoln
Mrs. Abe S. Brown, 68 White
Mrs. Clarence H. Cole, 119 Coniston Ave.
Mrs. Morris Coshak, 58 Holmes Ave.
Mrs. Thomas Cottiero, 21 Cooke
Mrs. Rudolph Damiani, 5 Cooke
Mrs. Ralph DeCristoforo, 84 Newton Ter.
Mrs. Alfred Dreher, 292 Gaylord Dr.,
Mrs. Christopher Dwyer, 18 Pine
Mrs. John Freiheit, 85 Grove
Mrs. William M. Good, 219 Columbia Blvd.
Mrs. Jacques Green, 192 Euclid Ave.
Mrs. William Grillo, 16 Corona Dr.
Mrs. Millard Hanson, 44 Center
Mrs. Albert E. Herrmann, 142 Robinwood Rd.
Mrs. Joseph L. Hetzel, 81 Euclid Ave.
Mrs. Milton Jennes, 277 Columbia Blvd.
Mrs. Sidney W. Jennes, 107 Farmington Ave.
Mrs. Frank Karlin, 167 Farmington Ave.
Mrs. Edward Kirschbaum, Eastfield Rd.
Mrs. Lawrence Koleshko, 493 Watertown Ave.
Mrs. Frederick C. LaBrecque, 132 Columbia Blvd.
Mrs. William J. Lenkowski, 38 Euclid Ave.
Mrs. Edward Lewicki, Montoe Rd.
Mrs. Elliott Mayo, 129 Prospect
Mrs. Harold Morrill, 300 West Main
Mrs. John J. Mullen, 26 Calumet
Mrs. Thomas Mulligan, 45 Over
Mrs. Irving S. Platt, 45 Prospect
Mrs. Robert Pollard, 76 Euclid Ave.
Mrs. Joseph Reynolds, 185 Pine
Mrs. Harold A. Rosenberg, 253 Lincoln
Mrs. Jacob Saltzman, 41 Prospect
Mrs. Vincent Shea, 90 Tower Rd.
Mrs. Joseph Sklaver, 310 Pine
Mrs. H. J. Stettbacher, 17 Revere

Mrs. Arthur Sullivan, 136 Arden Rd.
Mrs. Paul Teiger, 221 Cooke
Mrs. James Tynan, 67 Eastwood Ave.
Mrs. Anthony Vastola, 20 Cables Ave.
Mrs. Frederick Wilcox, 200 Plaza Ave.
Mrs. Frederick Zerkowitz, 1803 East Main
Mrs. Seymour I. Zonn, 36 Holmes Ave.

WATERTOWN

Mrs. Joseph D. Collins, 326 Woodbury Rd.
Mrs. Chris Neuswanger, 64 Hillcrest Ave.
Mrs. J. Harold Root, Thomaston Rd.

WEST HAVEN

Mrs. Harold S. Appell, 354 Campbell Ave.
Mrs. Carl Giannotti, 399 Savin Ave.
Mrs. Frederick Kessler, 233 Elm
Mrs. William O'Connell, 295 Main

WOODBRIDGE

Mrs. William Perham, Amity Rd.
Mrs. Paul Vestal, Amity Rd.
Mrs. Arthur Yudkin, Tallwood Rd.

WOODMONT

Mrs. Alexander B. Timm, Jr., Morningside Dr.

YALESVILLE

Mrs. Henry Caplan, Main

New London County

COLCHESTER

Mrs. Irving Friedman, 16 Norwich Ave.
Mrs. H. P. Schwarz, 7 Broadway

GROTON

Mrs. E. L. Douglass, 198 Thames
Mrs. Eric Goldmeier, 306 Thames
Mrs. C. Tyson Hewes, 185 Thames
Mrs. Duncan MacDougall, 42 Ramsdell

LYME

Mrs. Julian Ely, R. F. D. No. 2

MYSTIC

Mrs. B. B. Crandall, 31 Gravel
Mrs. Roger Fowler, 5 Liberty
Mrs. E. R. Hill, 43 Main
Mrs. Thurman Maine, 64 Washington

NEW LONDON

Mrs. Ross E. Black, 345 Montauk Ave.
Mrs. Eric Blank, 36 Shirley Lane
Mrs. John F. Brosnan, 223 Glenwood Ave.
Mrs. George Cheney, 179 Montauk Ave.
Mrs. Louis DeAngelis, 193 Montauk Ave.
Mrs. Charles Dyer, 102 Montauk Ave.
Mrs. Milton Fabricant, 275 Montauk Ave.
Mrs. Joseph Ganey, 16 Elliot Ave.
Mrs. Edward Gipstein, 175 Parkway
Mrs. Frederick Hartman, 219 Glenwood Ave.
Mrs. I. Hendel, 336 Pequot Ave.
Mrs. Robert Henkle, 154 Williams
Mrs. Harold Irwin, 158 Williams
Mrs. Saul Karpel, 275 Glenwood Ave.
Mrs. Charles Kaufman, 16 Jerome Court
Mrs. Charles Krinsky, 951 Ocean Ave.
Mrs. Hugh Lena, 154 Broad
Mrs. Anthony Loiacano, 291 Vauxhall
Mrs. Richard Loiacano, 260 Broad
Mrs. Willard Morse, 32 Channing
Mrs. Thomas Murray, 32 Huntington
Mrs. Tage Nielsen, 195 Williams
Mrs. Albert G. Rapp, 261 Gardner Ave.
Mrs. Philip Savage, 203 Ledyard
Mrs. Victor Smilgin, 265 Williams
Mrs. James Sturtevant, 223 Ledyard
Mrs. Morris Sulman, 14 Greenway Rd.
Mrs. Hill Warren, 164 Hempstead
Mrs. Carl H. Wies, 756 Pequot Ave.
Mrs. Frank Wilson, 127 Glenwood Ave.
Mrs. Joseph C. Woodward, 40 Guthrie Pl.
Mrs. Joseph Wool, 803 Montauk Ave.

NORWICH

Mrs. Mario Albamonti, 46 Rockwell
Mrs. H. A. Bergendahl, 167 Harland Rd.
Mrs. C. E. Bielecki, 40 Harland Pl.
Mrs. Hugh Campbell, 111 Broad
Mrs. William T. Driscoll, 161 Broadway
Mrs. Sidney Drobnes, Harland Rd.
Mrs. M. A. Ferrara, Uncas-On-Thames
Mrs. George Gildersleeve, 100 Harland Rd.
Mrs. Louis Guss, Robbins Court
Mrs. H. W. Higgins, 4 Cachem Ter.
Mrs. Winfield Kelly, Uncas-On-Thames
Mrs. Joseph Mahoney, Ox Hill Rd.
Mrs. John Martin, 153 West Thames
Mrs. Maurice Moore, Laurel Hill
Mrs. N. Phillips, 38 Thirteenth
Mrs. Albert Quintiliani, 35 Williams
Mrs. Solam Segel, 20 Bliss Pl.
Mrs. John Suplicki, 40 Slater Ave.
Mrs. David Sussler, 34 Rockwell
Mrs. Clarence Thompson, Canterbury Tpke.
Mrs. William V. Wener, 22 Harland Pl.

OLD LYME

Mrs. Harold Von Glahn

STONINGTON

Mrs. Henry Haines, Pequot Trail
Mrs. Willard Veal, 99 Water

TAFTVILLE

Mrs. H. A. Archambault

WATERFORD

Mrs. Walter Lukoski, Seaside Sanitorium
Mrs. J. F. O'Brien, Seaside Sanitorium
Mrs. Richard Star, Best View
Mrs. S. P. Tombari, Seaside Sanitorium

Windham County

DANIELSON

Mrs. Gerard M. Chartier
Mrs. Cecil R. Garcin
Mrs. Andrew O. Laakso, 213 North Main
Mrs. Warren A. Tanner, 36 Academy

HAMPTON

Mrs. Arthur D. Marsh

MANSFIELD CENTER

Mrs. Kenneth K. Kinney

MANSFIELD DEPOT

Mrs. Neil A. Dayton
Mrs. Herbert L. Flynn

MOOSUP

Mrs. John A. Woodworth

PUTNAM

Mrs. Robert Dinolt
Mrs. Karl T. Phillips, 36 Church
Mrs. William Mac Shepard

STORRS

Mrs. Ralph L. Gilman, Willowbrook Rd.

WILLIMANTIC

Mrs. Edward H. Basden
Mrs. George H. Carter, 158 Chestnut
Mrs. Joseph A. Girouard, 250 Pleasant
Mrs. Reuben Rothblatt, 25 Whiting
Mrs. Nathan Spector
Mrs. Sidney Vernon

WINDHAM

Mrs. Morton Arnold
Mrs. Conrad S. Baker
Mrs. Edward J. Ottenheimer

WOODSTOCK

Mrs. David H. Bates

Members at Large

ROCKVILLE

Mrs. Orlando J. Squillante, 28 Elm

SOMERS

Mrs. Ralph B. Thayer

Governor Dewey on Socialized Medicine

In addressing the House of Delegates of the Oregon State Medical Society Governor Dewey boldly and uncompromisingly declared:

"Compulsory socialized medicine is no good, no variation of it is any good. It has never worked wherever it has been tried; it cannot be done; it never will be done.

"Accordingly I have spent the last two years of my life knocking down every proposal that anybody has made to regiment the medical profession and the people of America through any program of socialized medicine.

"By making speeches publicly at every meeting of people that would listen to me on the subject, I have made it clear that we have actually been through this thing, about which it has cost the people of my state $200,000 to find out. I don't want that money wasted. I don't want to run the risk of having happen to the health of our people that which has happened to the health of every group of people which has tried to drag the medical profession down to the Socialists' level.

"You won't drag anything up. You will enlarge the volume of medical care, but you will utterly destroy the quality of medical care the minute you try that process.

". . . if a thing is evil, the first job is to convince people that it is evil and thoroughly evil and destroys everything that we believe in.

"This idea which has been shared by the last two occupants of the White House that you can improve medical care by passing a law must be stopped.

"Let's get them all understanding and working and they won't want to be putting you in jail with socialized medicine. I am unalterably opposed to it. It won't work and will lower our standard, and I venture our death rate would mount from the very day it was passed."

At the conclusion of his talk one of the delegates asked, "If you get to the White House what are you going to do about Falk, Altmeyer and their crew?" He replied, "Gentlemen, there will be the greatest housecleaning Washington has ever seen."

SPECIAL NOTICES

CONNECTICUT VA MEDICAL SOCIETY

Sponsored by the Connecticut Veterans Association Medical Society, the following clinical conferences will be held during August at the Veterans Administration Office, 355 Fairfield Avenue, Bridgeport, from 8:30 to 9:30 A. M. on the dates indicated:

August 4—Common Manifestations of Anxiety
George K. Pratt, M.D., associate neuro-psychiatrist, Bridgeport Hospital

August 11—Otitic Damage
Edward R. Roberts, M.D., otolaryngologist, Bridgeport Hospital

August 18—Functional Evaluation of the Cardiac Patient
M. D. Deren, M.D., internist, Bridgeport

August 25—Radiological Demonstration of Unusual Bone Disease
Joseph J. Esposito, M.D., associate radiologist, Danbury and Bridgeport Hospitals

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-sixth annual scientific and clinical session September 7, 8, 9, 10 and 11 inclusive, at the Hotel Statler, Washington, D. C. Scientific and clinical sessions will be given the days of September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 7, 8, 9 and 10. These courses will be offered in two groups. One set of ten lectures will be based primarily on physics and physiology and attendance will be limited to physicians. One set of ten lectures will be more general in character and will be open to physicians as well as to physical therapists. The physical therapists must be registered with the American Registry of Physical Therapy Technicians. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

TWO WEEKS' COURSE IN CEREBRAL PALSY FOR PHYSICIANS

Place—Michael Reese Hospital Postgraduate School, Chicago, Illinois.

Time—August and October (exact dates to be announced).

Instructor—Dr. Meyer Perlstein of Chicago.

Others—Speech Department of Northwestern University.

For further information please write to Michael Reese Hospital Postgraduate School, Chicago, Illinois.

BONE AND JOINT PATHOLOGY COURSE

The course in the pathology of bones and joints given at the Hospital for Joint Diseases, New York City, will now be conducted personally by Dr. Henry L. Jaffe. The course will survey systematically the entire field of bone and joint pathology (including the pertinent roentgenology, bacteriology, and biochemistry). For the year 1948-49 there will be a twelve weeks' course during the fall and another during the spring. Applications (for the fall or spring course) and requests for further information should be made in writing to Dr. Henry L. Jaffe, 1919 Madison Ave., New York 35, N. Y.

THE AMERICAN COLLEGE OF PHYSICIANS ANNOUNCES ITS ANNUAL SESSION AT NEW YORK CITY MARCH 28 - APRIL 1, 1949

The American College of Physicians will conduct its 30th Annual Session at New York, N. Y., March 28 through April 1, 1949. Dr. Franklin M. Hanger, Jr., of New York City is the chairman for local arrangements and the program of Clinics and Panel Discussions. The President of the College, Dr. Walter W. Palmer, director of the Public Health Research Institute of the City of New York, Inc., and professor emeritus, Columbia University College of Physicians and Surgeons, is in charge of the program of Morning Lectures and afternoon General Sessions.

Secretaries of medical societies are especially asked to note these dates and, in arranging meeting dates of their societies, to avoid conflicts with the College Meeting, for obvious mutual benefits.

RESEARCH FELLOWSHIPS — THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1949 - June 30, 1950. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work.

The stipend will be from $2,200 to $3,200.

Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than November 1, 1948. Announcement of the awards will be made as promptly as is possible.

OBITUARIES

Edmund L. Spicer, M.D.

1881 - 1948



On April 12, 1948 Dr. Edmund L. Spicer died suddenly at his home. He had been in ill health for some time, and a short time before his death had been a patient at the Waterbury Hospital.

Born on September 6, 1881 in Groton, he had grown up in that section of Connecticut, attending the Buckley School for Boys in New London, graduating in 1901. He then entered the Yale University Medical School, graduating in 1905. He spent the next year as intern at the Lincoln Hospital in New York City.

In November 1906 Dr. Spicer received his Connecticut State license to practice, and in January 1907 began his long and successful practice of medicine and surgery in Waterbury. He became a member of various professional associations including the Waterbury Medical Association, New Haven County and Connecticut State Societies, and American Medical Association. In 1924 he became a fellow of the American College of Surgeons.

In recent years, even though declining health had limited his active practice in medicine and surgery very materially, Dr. Spicer's continued deep interest in professional matters is shown by his becoming a member of the comparatively new group organized under the name of the Waterbury Geriatrics Association.

In World War I he entered the U. S. A. Medical Corps as a First Lieutenant on April 16, 1918; trained at Camp Mills, Mineola, Long Island; and in September 1918 was transferred to Brest, France. Taken ill on shipboard during the trip to France, he had to be hospitalized because of influenza-pneumonia, and so put on inactive status. Recovery from this serious illness was long delayed, and he was finally sent back to this country for further convalescence, and was discharged from service at Camp Mills in May 1919, still with the commission of First Lieutenant.

Dr. Spicer was attending surgeon at the Waterbury Hospital from 1916 to 1924; full attending surgeon from 1924 to 1933; consulting surgeon from 1933 to 1936; honorary surgeon from 1936 to 1948. He was a member of Euclid Lodge, No. 135, A. F. & A. M. He had not much time for hobbies but did enjoy target practice with a rifle and was always fond of music and the theatre.

He was always keenly interested in political trends, not only locally, but also in the state and nation, and the recent trends toward bureaucracy found no favor in his mind.

He is survived by his widow, Minnie Tracy Chatfield Spicer, whom he married on December 17, 1912.

Dr. Spicer, while not slow to appreciate real advances in medicine and surgery, and to add such new methods and medicines to his own armamentarium, had little patience with other practitioners who let their enthusiasm for new things get the better of their common sense. It seemed to him that time tested methods should be relied upon by men who dealt with sickness day in and day out to such an extent that they had no time for real scientific research, and adopt new methods only when proved beyond a doubt to be of value by men who were in a position to experiment with and to evaluate such new advances.

He was also very much distressed by what seemed to him to be commercialization of medicine, and it was difficult for him to understand why a medicine that could be prescribed safely for oral administration and be effective wasn't better for the patient, economically at any rate, than to require the patient to visit the physician at frequent intervals for administration of the same or similar preparation by injection methods at a very much greater expense to the patient.

Dr. Spicer will be greatly missed by a great many people in Waterbury, both his old patients and his friends.

E. L. Smith, M.D.,
O. J. Bizzozero, M.D.,
H. F. Morrill, M.D.

William Nelson Winne, M.D.
1872 - 1947



Dr. William Nelson Winne, son of Charles and Mary E. Winne, was born February 23, 1872 in Independence, Iowa, and died October 30, 1947 at his home at 1020 Whalley Avenue, at the age of seventy-five. He married Nellie Dean of Westfield, Massachusetts, in 1898 and she died in 1939.

Dr. Winne attended Williston Seminary, Northampton, Massachusetts, and the New York University Medical School where he received his M.D. degree in 1897.

Following his graduation in medicine he opened an office in Windsor, Connecticut where he practiced for a few months, later removing to Westville where he continued in general practice until his death. His activities had been limited for a number of months on account of a heart ailment from which he eventually died.

In 1917, while crossing the street, he was struck by a car, receiving several fractured ribs. X-rays taken at that time also showed tuberculosis. As a result of the above mentioned conditions he was forced to give up an extensive practice for two years, and for the following fifteen years felt it necessary to take four months off for rest yearly, in spite of which handicap he led a busy and successful professional life.

Dr. Winne was much beloved by his patients who remained loyal to him during the years when his activities were necessarily limited. He had an excellent kindly and whimsical sense of humor and a high sense of honor which endeared him to a large circle of friends.

For an eight year period Dr. Winne served as clinical assistant in pediatrics at the Yale Medical School, and for a similar period as clinical assistant in ophthalmology and otolaryngology. He had been medical examiner for the towns of Woodbridge and Bethany since 1906, and has been a member of the New Haven City and County Medical Societies, as well as the State and American Medical Associations.

Dr. Winne is survived by a brother, Charles I. Winne, a dentist in Essex, Connecticut and by a half brother, Carrol LaPlace of Washington, D. C.

Thomas H. Russell, M.D.

John G. O'Connell, M.D.
1891 - 1948

It is with deep sorrow and sincere sympathy that one acknowledges the loss of a fine surgeon, a fellow staff member, and personal friend.

John G. O'Connell was born in Bridgeport March 18, 1891. He was educated in the public schools of that city and following graduation from Central High School entered Fordham University. Following premedical study at Fordham he went on to Tufts College Medical School in Boston and received his medical degree in June of 1917. He then spent the year, 1917-18, in an internship at the Bridgeport Hospital, Bridgeport.

During World War I he served with the United States Army Medical Corps with the rank of cap-



JOHN G. O'CONNELL, M.D.

tain and was attached to a base hospital in France. At the close of the war he returned to Bridgeport and began private practice, soon becoming a member of the surgical staff at the Bridgeport Hospital.

On March 28, 1921 Dr. O'Connell married Madeleine Barwin of Bridgeport and they became the parents of three children, M. Patricia, John Jr., and Madeleine.

Dr. O'Connell was very active in city and state medical circles. He was a Fellow of the American College of Surgeons, a member of the Bridgeport, Fairfield County, Connecticut State, and American Medical Associations.

John O'Connell was, in many ways, an unusual man. He lived his life happily and well; he worked hard and played hard. His personal interests were chiefly centered around his family and home, his friends and golf.

In 1945, due to a heart ailment, Dr. O'Connell resigned from the surgical staff of the Bridgeport Hospital, closed his private practice and moved to Florida.

In 1947 he returned to Connecticut and assumed the position as medical specialist with the Veterans Administration in Hartford, a position which he held until his death on April 6, 1948.

Dr. John O'Connell was one of those wholesome and fine characters with whom it was always a privilege to serve.

Maurice L. Cheney, M.D.

OUR NEIGHBORS

Massachusetts

Boston reports 2 cases of typhus fever occurring in persons who have lived in that city for many years. (See N. E. J. Med., June 17, 1948.)

The new president-elect of the Massachusetts Medical Society is Daniel B. Reardon. This Society has now established a full time secretaryship.

New York

The new president-elect of the Medical Society of the State of New York is John J. Masterson, practising roentgenologist in Brooklyn. Dr. Masterson is a past president of the Medical Society of the County of Kings and has been a member of the House of Delegates of the American Medical Association since 1935.

* * * *

Thirty thousand union employees of 150 New York City hotels will soon have their own medical center.

Estimated to cost $1,000,000, the center will be located in a building formerly housing the Y. W. C. A. at Fiftieth Street and Tenth Avenue. The property was recently purchased by hotel operators through the New York Hotel Trades Council and the Hotel Association of New York. The five-story building will be remodeled to provide facilities for general medical care, specialist examining rooms, laboratory procedures, x-ray treatments, immunization, and other disease prevention measures. Treatment of workmen's compensation cases will not be included, but all other medical care will be furnished employees without charge, according to Jay Rubin, president of the Hotel Trades Council. The medical center will be governed by a joint board of dierctors of the two organizations.

NEWS
from County Associations

Fairfield

David Deren, 562 Boston Avenue, Bridgeport, was moderator at a round table discussion at a meet-

ing of the American Geriatrics Society on the subject of "Problems of Aging." This meeting was held in the Stevens Hotel, Chicago, preceding the annual American Medical Association convention.

Hartford

Stanley H. Osborn, State health commissioner, was elected the first president of the Tufts Medical Alumni Club of Hartford County at the organization meeting of the club held in April. Harry L. F. Locke of Hartford was elected secretary-treasurer.

Hartford Hospital plans to expand its diagnostic clinic this fall so that almost 90 per cent of the city's residents will be eligible for its services. The present income ceiling of $3,500 will be increased to include semi-private patients. The expanded clinic will be organized along the lines of some of the most famous diagnostic clinics in the nation. Treatment will not be given by the clinic but by the patient's own physician.

Albert J. Robinson, vice-president and medical director of the Connecticut General Life Insurance Company, and Edward A. Keenleyside, associate medical director of the same company, participated in the 36th annual meeting of the medical section of the American Life Convention held at Bretton Woods, N. H., in June. Dr. Robinson is also president of the Association of Life Insurance Medical Directors.

Charles A. Goodrich of Hartford, a pioneer in the field of pediatrics, died in that city on June 13. Dr. Goodrich practiced in Hartford for about 50 years. He was president of the Hartford Medical Society in 1924, of the County Association in 1908, and secretary of the Hartford Hospital staff from 1923 to 1932.

Leopold M. Trifari of Providence, R. I., has been appointed assistant to Stevens J. Martin, director of the school and department of anesthesiology at St. Francis Hospital.

Harold F. Pierce has retired from private practice in Hartford to become senior physician at the Rocky Hill Veterans Home.

Donald C. Gordon of Hazardville, a medical missionary in Brazil, received the honorary degree of Master of Arts at the Wesleyan commencement on June 13.

James S. Rooney of Hartford has retired after forty years as school physician. Pupils of the Brown and Kinsella Schools gave him a farewell party.

Litchfield

A group of general practitioners, members of the American Academy of General Practitioners, recently met in Litchfield to organize a Litchfield County Chapter. The following officers were elected: President, John F. Kilgus, Jr.; Vice-President, Albert W. Dautrich; Secretary-Treasurer, Sidney A. Chait. At this organization meeting, various problems of particular interest to the general practitioner were discussed. A strenuous effort is being made to recruit the general practitioners of the state into the American Academy of General Practitioners. The State Chapter has now been granted a charter, and we believe that Litchfield County is pioneering in the formation of a County Chapter. We believe that this is a worthy project, as the general practitioner's problems differ so greatly in different sections of the state, and it is our feeling that a County group will be most helpful in promoting and maintaining high standards for the general practitioner in Litchfield County. Any of the general practitioners in the state who are interested in affiliating themselves with the newly-organized group are asked to get in touch with Dr. Sidney A. Chait, 106 Litchfield Street, Torrington. Announcement of the next meeting will be sent to all the physicians in the County who are enrolled in the State Chapter.

Middlesex

J. Clifford Scott of Essex has terminated his practice to accept the position of superintendent of the Oakbourne Colony Hospital, West Chester, Pa.

Bertram E. Marks, M.D., of Brooklyn, New York, has been appointed health officer for Middletown to succeed George B. Davis, recently resigned.

New Haven

Dr. William Mendelsohn was named recently to succeed Dr. Frederick W. Roberts, who has been an active leader in the work of the New Haven Branch of the Connecticut Cancer Society for many years. The new Society head is a graduate of Johns Hopkins Medical School; has done cancer research work at Crocker Institute in New York and Carnegie Institution of Washington in Baltimore, and is attending surgeon and chairman of the Tumor Clinic at Grace Unit of Grace-New Haven Community Hospital.

David E. MacQuigg has resigned as physician anesthesist at the Meriden Hospital to accept a

position at the William Beaumont Hospital, El Paso, Texas. Dr. MacQuigg will be in charge of anesthesia and of the operating room at this Army hospital.

Carter L. Marshall, M.D., of New Haven was re-elected to serve a seventh term as president of the New England States Association of Elks of the World.

New London

William V. Wener of Norwich and Henry A. Archambault of Taftville have just completed a most interesting and instructive course in surgical anatomy at the Cornell University Medical College under the able direction of Professor E. W. Lampe. Dr. Wener also took a fracture course at the Lenox Hill Hospital, New York, under the direction of Sir Reginald Watson Jones of London, England. Both men were most enthusiastic over the courses and felt that the time spent was really worthwhile.

Ralph Falcone has completed his internship at the W. W. Backus Hospital, Norwich and has started a residency training in surgery at the Wesson Memorial Hospital, Springfield, Mass.

Frank James has completed his internship at the W. W. Backus Hospital, Norwich, and leaves to set up private practice in Oklahoma.

The following 4th year medical students are serving as junior interns for the summer months at the W. W. Backus Hospital and will return to their respective schools in September: Ray F. Beers, Jefferson Medical College, Philadelphia; Chester W. Eskey, Jefferson Medical College; Coleman Jacobson, Iowa Medical College; and Clifford E. Wilson, Jr., a 3rd year medical student, University of Maryland Medical College.

David Rousseau has opened an office in Taftville for the practice of medicine and surgery. He is a graduate of the University of Vermont School of Medicine, 1945; served as resident intern at the W. W. Backus Hospital, July 1945 - July 1946; and later joined the Armed Forces being assigned to the Veterans Hospital at Togas, Maine, where he remained about two years. He has the good wishes of the medical fraternity in this vicinity and we are all quite sure that he will make a good addition, in every way, to the civic and medical life of Taftville.

Reuben Rothblatt of Norwich has been appointed chairman of the advisory committee of the infantile paralysis drive for the Windham County area.

Tolland

The State Highway Department has designated Route 31 as the William Lincoln Higgins Highway in honor of Dr. William L. Higgins of South Coventry. The highway has been suitably marked following a vote passed in the last General Assembly. Dr. Higgins recently retired as local health officer.

News from Yale University School of Medicine

Dr. Norton Canfield has been elected a member of the Collegium Oto-Rhino-Laryngologicum Amicitiae Sacrum, an organization in which 25 countries are represented. Not more than 10 active members are selected from each country. The next meeting of the College will be held in Copenhagen, September 1-4, 1948 which Dr. Canfield plans to attend.

NEW BOOKS IN REVIEW

THE ACUTE BACTERIAL DISEASES—THEIR DIAGNOSIS AND TREATMENT. By Harry F. Dowling M.D., F.A.C.P., Clinical Professor of Medicine, George Washington University; Chief, George Washington Medical Division, Gallinger Municipal Hospital; *with the Collaboration of Lewis K. Sweet,* M.D., Chief Medical Officer in Pediatrics and Infectious Diseases, Gallinger Municipal Hospital; Adjunct Clinical Professor of Pediatrics, George Washington and Georgetown Universities; and *Harold L. Hirsh,* M.D., Assistant Professor of Medicine, Georgetown University; Director of the Bacteriology and Immunology Laboratory, Georgetown University Hospital. *Philadelphia and London: W. B. Saunders Company.* 1948. 465 pp. with 55 fig. $6.50.

Reviewed by JOHN T. BEEBE

To the conscientious physician who has been able to keep abreast of the current literature on the treatment of infectious diseases, and who has not been lured into a false sense of security by the advent of the antibiotics, this book will be no more than a concise but thorough review.

To the physician who on the contrary either willfully or wantonly has used these new drugs without adequate knowledge of their advantages or their limitations, this book will serve as an extremely useful and timely guide.

The principles of therapy referred to are a radical departure from those taught prior to the advent of the antibiotic era. In other words we are no longer primarily concerned with the pathological effects of a disease process but rather with the etiological agent. Knowing the latter first and treating it adequately with a known specific

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VILES

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drug, the pathological end point can be predicted in modified form or perhaps prevented.

The content of the discussion is a review of many of the old concepts of infectious disease in the light of our newer conception of therapy. The first chapter is an interesting and novel orientation, offering a means of narrowing the diagnostic possibilities of infectious diseases by a consideration of major localizing signs and symptoms. This is followed by a detailed description of each of the modern methods of therapy included in which are (1) Serum Therapy, (2) Sulfonamide Therapy, (3) Penicillin Therapy, and (4) Streptomycin Therapy. Aside from thereby acquiring an up-to-date review of these vital agents, the importance from a clinical standpoint is the changes and improvements in laboratory procedures used in diagnosis and the toxicological factors, the knowledge of which precludes the use of any of these drugs.

The remainder of the book is devoted to a review of various diseases classified according to the etiological agent. One section being devoted to diseases caused by Cocci, the second section to diseases caused by Bacilli, and the third to bacterial diseases in which Exotoxins are a major factor. All of these are presented with a minimum of detail, but with the essential factors of clinical importance namely those which may shorten the distance between clinic and laboratory, facilitate accurate diagnosis and ensure opportune, specific therapy.

In conclusion there is embodied in the 450 pages of the text good medicine for untutored physicians who have been using the antibiotics empirically, or as an obligation to public opinion.

ADVANCES IN MILITARY MEDICINE. Made by American Investigators Working Under the Sponsorship of The Committee on Medical Research. *Edited by E. C. Andrus, D. W. Bronk, G. A. Carden, Jr., C. S. Keefer, J. S. Lockwood, J. T. Wearn, M. C. Winternitz. Associate Editor, Tuckerman Day.* Foreword by *Alfred N.* Richards. Science in World War II Series. *Boston: Little, Brown & Co.* 1948. 2 vols. 900 pp. $12.50.

Reviewed by STANLEY B. WELD

The Office of Scientific Research and Development, through a huge cooperative effort, produced results in medical research during World War II which will long remain typical of American ability in a crisis. The Committee on Medical Research was set up by the President prior to the entrance of our nation into the War, i.e., on June 28, 1941. At the same time the parent organization, the Office of Scientific Research and Development, was created and placed under the directorship of Dr. Vannevar Bush. OSRD was directed to "utilize the laboratories, equipment and services of governmental agencies and institutions to the extent that such facilities are available for such (research) purposes."

These two volumes are concerned with an account of the development, improvement and utilization of certain weapons and of the application of the medical knowledge of these weapons to military situations. Advances made in three fields in particular stand out: viz., insecticides, antimalarials, and penicillin. But in addition to these, research in neurology and psychiatry, in other tropical diseases than malaria, in syphilis, aviation medicine, burns, gas gangrene, chemical warfare agents, in nutrition, and in the many problems of physiology all received the attention of the nation's experts.

The list of research contracts drawn by the Office of Scientific Research and Development on the recommendation of the Committee on Medical Research is worthwhile studying. This list appears at the end of Volume II. Yale University was a partner to 13 of these contracts covering investigations in bacillary dysentery, in the prevention of protein wastage, in peritonitis, wound ballistics, anoxia and decompression effects, in shock, lung irritation in gas casualties, healing of tissues exposed to vesicant gases, in adrenocortical hormone research, and in the compilation of bibliographies of aviation medicine and of visual references.

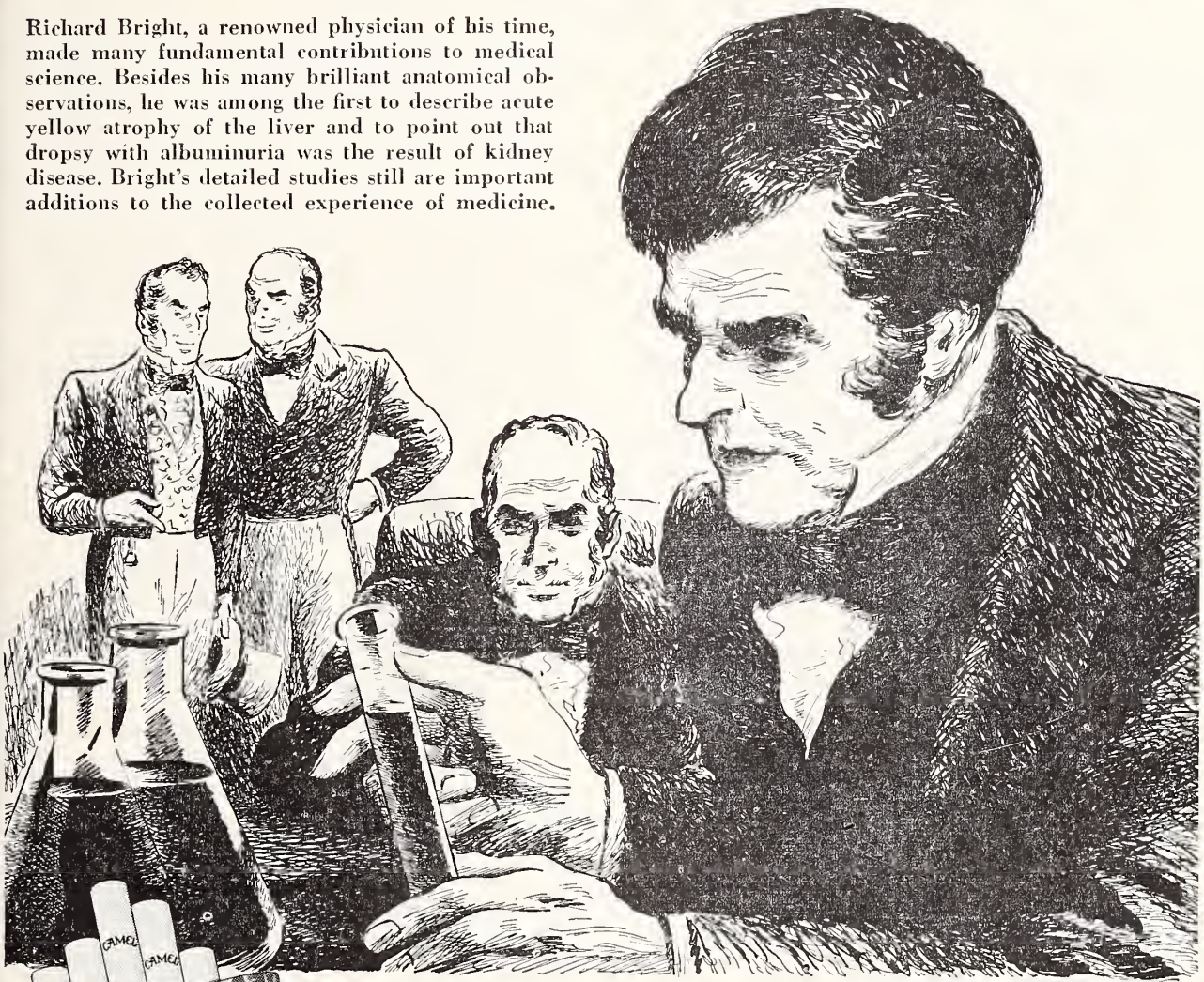
Connecticut medicine may point with pride to work done by John F. Fulton, Samuel C. Harvey, John P. Peters, Milton C. Winternitz, C. N. H. Long, William T. Salter, Ashley W. Oughterson, Gervase J. Connor, Ernest Mylon, and Henry Bunting.

A well known reviewer for one of this country's leading newspapers comments on the contrast our feeble peacetime medical research produces compared to the organized planning as carried out in World War II. OSRD knew what it wanted, developed working committees, and dug up the best scientific minds to gain results. Some of the problems remain unsolved; able scientists still abound to carry on to achieve such victories as have been experienced with penicillin and the antimalarials.

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Treasurer: Clifton C. Taylor, 881 Lafayette St., Bridgeport
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Annual Meeting, Second Tuesday in April, at Bridgeport
Semi-Annual Meeting, First Wednesday in October

BETHEL

1945 Mandl, George, 81 Greenwood Ave.
1925 Moore, H. Frank, 4 Grand Ave.
1938 Trimpert, Albert Joseph, 155 Greenwood Ave.
1939 Wolfson, Dexter, 58 Greenwood Ave.

BRIDGEPORT

1946 Abrahamson, Robert H., 588 State
1933 Adzima, Joseph Matthew, 409 Noble Ave.
1941 Akerson, Irving B., Bridgeport Hospital
1932 Alpert, Max, 881 Lafayette
1944 Amarant, Leo, 881 Lafayette
1935 Antell, Maxwell Joseph, 800 Clinton Ave.
1920 Apsel, Abraham, 1620 Fairfield Ave.
1942 Apuzzo, Anthony Albert, 919 Fairfield Ave.
1948 Aube, Louis Armond, 2708 Main
1928 Backer, Marcus, 881 Lafayette
1938 Bakunin, Maurice Irving, 881 Lafayette
1916 Banks, Daniel Tony, 385 Barnum Ave.
1913 Beaudry, Joseph Horace, 109 Rowsley
1941 Beck, Sidney Henry, 881 Lafayette
1941 Bellew, Raymond F., 905 Clinton Ave.
1913 Bernstein, Abraham, 881 Lafayette
1946 Birney, Thomas Peter, 1984 Park Ave.
1935 Bogin, Maxwell, 144 Golden Hill
1921 Booe, J. Grady, 144 Golden Hill
1947 Braun, Rudolf, 525 Clinton Ave.
1941 Brier, Hyman David, 2583 Main
1927 Brodsky, Michael Emanuel, 881 Lafayette
1940 Brooks, Paul Lester, 1260 East Main
1939 Buckhout, George Atherton, 144 Golden Hill
1938 Buckley, John William, 2080 North Ave.
1923 Buckmiller, Frank Charles, 1119 Stratford Ave.
1940 Burns, Bernard John, 1101 East Main
1919 Calvin, Claudius Virgil, 144 Golden Hill
1947 Camarda, Anthony L., 1776 North Ave.
1945 Capobianco, Arthur Paul, 932 East Main
1946 Cardone, Michael James, 2989 Main
1932 Carroll, Philip Roger, Jr., 1131 Noble Ave.
1947 Caserta, Silvio Joseph, 880 North Ave.
1940 Castaldo, Louis F., 10 Washington Ave.
1947 Cavaliere, Vincent J., 634 Washington Ave.
1920 Cheney, Maurice Lionel, 144 Golden Hill
1941 Clark, William Thompson, 881 Lafayette
1924 Conklin, Cornelius Stephen, 468 Clinton Ave.
1936 Connors, Edwin Robert, 416 Boston Ave.
1935 Creaturo, Nicholas Edward, 1286 East Main
1943 Crispin, Maximilian A., 1278 East Main
1913 Curley, William Henry, 881 Lafayette
1947 Curley, William Henry, Jr., 881 Lafayette
1908 Curran, Philip John, 144 Golden Hill
1894 Day, Fessenden Lorenzo, 819 Myrtle Ave.
1946 Delevett, Allen Fitzhugh, 144 Golden Hill
1920 DeLuca, Horatio Roger, 881 Lafayette
1935 Del Vecchio, Leonard Frederick, 60 Crown
1947 Deren, Moses David, 562 Boston Ave.
1921 DeWitt, Edward Nicholas, 881 Lafayette
1947 Donadeo, John, 1776 North Ave.
1945 Donnelly, William Augustus, 2112 North Ave.
1941 Duzmati, Paul Peter, 1904 Boston Ave.
1941 Eddy, Maxon Hunter, 144 Golden Hill
1939 Edgar, Katherine Jean, 144 Golden Hill
1937 Eimas, Aaron, 881 Lafayette
1948 Elliott, Frank George, Jr., 1741 Stratford Ave.
1946 Eskwith, Irwin Stanley, 881 Lafayette
1939 Esposito, Joseph John, 144 Golden Hill
1938 Findorak, Francis George, 895 Huntington Rd.
1943 Fink, Lisbeth, 3166 Main
1913 Finkelstone, Benjamin Brooks, 1854 North Ave.
1938 Foley, Francis Xavier, 3100 Main
1916 Gade, Carl Johannes, 144 Golden Hill
1939 Gaffney, Charles Bernard, 610 Brooklawn Ave.
1929 Garbelnick, David Abraham, 1102 East Main
1907 Gardner, Charles Wesley, 144 Golden Hill
1916 Garlick, George Burroughs, 144 Golden Hill
1940 Geer, William Allyn, 881 Lafayette
1916 Gilday, James Lowry, 819 State
1927 Gildea, Mark Andrew, 881 Lafayette
1895 Gold, James Douglas, 839 Myrtle Ave.
1943 Golomb, Evelyn Frances, 2583 Main
1946 Goodrich, William J., 3120 Fairfield Ave.
1927 Greenspun, David Stoven, 144 Golden Hill
1916 Griffin, Daniel Patrick, 1278 East Main
1923 Griswold, Arthur Sheldon, 144 Golden Hill
1928 Griswold, Crawford, 144 Golden Hill
1920 Groark, Owen James, 881 Lafayette
1943 Grossman, John Henry, 144 Golden Hill
1941 Gulash, John Robert, 573 Stillman
1913 Hale, Fraray, 144 Golden Hill
1941 Hall, R.. Warren, 31 Hilltop Drive, Nichols
1947 Hanley, James Leo, Jr., 928 Lafayette

1939 Hardenbergh, Daniel Bailey, 144 Golden Hill
1928 Harshbarger, Isaac Long, 144 Golden Hill
1946 Hart, Benjamin Ide, 453 State
1920 Havey, Leroy Austin, 144 Golden Hill
1938 Hennessey, Joseph Gerard, 482 Brewster
1915 Hippolitus, Paul DiFrancesca, 269 Barnum Ave.
1930 Hooper, G. Herbert, 1633 East Main
1933 Horn, Benjamin, 754 Clinton Ave.
1916 Horn, Martin Irving, 915 North Ave.
1946 Horowitz, Isaac, 1336 Fairfield Ave.
1920 Howard, Joseph Henry, 144 Golden Hill
1912 Hyde, Charles Elias, 881 Lafayette
1948 Ives, Eli Bolton, 320 West Ave.
1932 James, Arthur Gregory Boswell, 1424 Stratford Ave.
1944 Johnstone, Kermit Thomas, 939 Barnum Ave.
1943 Jones, Elwood King, 881 Lafayette
1932 Kalman, Eugene, 622 Clinton Ave.
1942 Kaplan, Leon, 881 Lafayette
1941 Kaufman, William, 541 Brooklawn Ave.
1927 Keegan, Daniel Francis, 144 Golden Hill
1948 Kenigsberg, Nathaniel, 10 Washington Ave.
1946 Kinder, Frederick Stephen, 144 Golden Hill
1946 Kleinman, Harold Louis, 2051 North Ave.
1924 Kneale, Halford Benson, 144 Golden Hill
1948 Kogut, Henry Vincent, 881 Lafayette
1924 Kornblut, Alfred, 1539 Fairfield Ave.
1943 Landecker, Norbert, 2895 Main
1926 Laszlo, Andreas, 881 Lafayette
1940 Lengyel, Paul, 500 Clinton Ave.
1946 Lenoci, Ralph Joseph, 1822 Noble Ave.
1943 Lesko, Joseph Michael, 144 Golden Hill
1925 Levenson, Albert, 881 Lafayette
1904 Leverty, Charles Joseph, 528 Park Pl.
1948 Levinsky, Aaron, 90 Princeton
1933 Levinsky, Maurice, 480 Noble Ave.
1927 Levy, Maurice Noel, 480 Clinton Ave.
1942 Lieberthal, Mliton Morton, 881 Lafayette
1931 Lockhart, Reuben Harold, 144 Golden Hill
1942 Lopatin, Colman, 588 State
1946 Lyddy, John Roger, 446 Stratford Ave.
1937 Lynch, Hubbard, 881 Lafayette
1887 Lynch, John Charles, 826 Myrtle Ave.
1904 Lynch, Robert Joseph, 144 Golden Hill
1947 Lynch, Vincent Aloysius, 928 Lafayette
1944 Lyon, Grover Arthur, 2009 North Ave.
1932 Marglis, Ben, 171 Harrison
1941 Martin, Raymond Alfred, 144 Golden Hill
1942 Massey, Daniel M., 1025 Noble Ave.
1922 Maxwell, John Alphonsus, 254 East Main
1945 McGovern, Edward F., 881 Lafayette
1938 McLean, Thomas Smith, Jr., 1403 Boston Ave.
1947 McNamara, Alexander P., 3354 Main
1913 McQueeney, Andrew Michael, 1315 Noble Ave.
1946 Meshken, Jacob, 928 Lafayette
1931 Meyer, Fritz Martin, 144 Golden Hill
1892 Miles, Henry Shillingford, 144 Golden Hill
1947 Molnar, George J., 261 Clinton Ave.
1940 Monahan, David Tuite, 144 Golden Hill
1932 Mooney, Sydney, 881 Lafayette
1946 Morris, Felix R., 953 East Main
1936 Murray, William Joseph, 144 Golden Hill
1948 Nagourney, David, 1756 East Main
1938 Nespeco, James V., 3180 Main
1901 Nettleton, Irving La Field, 775 Washington Ave.
1919 Neumann, Harry Aaron, 588 State
1948 Newman, Abbott A., 588 State
1937 Newton, Louis, 881 Lafayette
1925 Nichols, Charles Williams, 1221 Stratford Ave.
1920 Nickum, J. Stanley, 144 Golden Hill
1936 Nolan, John Francis, 1260 East Main
1947 Northman, Frank Fred, 1884 Park Ave.
1926 Oberg, Frank Thorwald, General Electric Co.
1947 O'Looney, John J., Jr., 1072 East Main
1943 O'Neill, John Joseph 1468 Stratford Ave.
1944 Oros, Louis Michael, 555 Clinton Ave.
1944 Oster, Kurt A., 881 Lafayette
1947 Owens, Andrew Paul, 385 Noble Ave.
1940 Panettieri, Andrew Joseph, 3084 Main
1942 Parker, Ralph Layton, 928 Lafayette
1921 Parmelee, Berkley Melvin, 144 Golden Hill
1937 Pascal, Thomas J., 1560 Noble Ave.
1944 Pasquariello, Domenico William, 2969 Main
1946 Pellens, Mildred, 1278 East Main
1930 Pileggi, Peter, 743 Washington Ave.
1932 Pitock, Morris Philip, 881 Lafayette
1935 Plukas, Joseph Martin, 339 South Ave.
1942 Popkin, Michael Sherman, 1671 Noble Ave.
1941 Pratt, George Kenneth, 881 Lafayette
1933 Quatrano, Joseph Charles, 893 Clinton Ave.
1916 Quinn, John Francis, 144 Golden Hill
1941 Quinn, Katherine Sarah, 2970 North Main
1916 Reich, Upton Sharetts, 2095 Main
1940 Reiter, Benjamin Reynolds, 144 Golden Hill
1942 Resnik, Harry, 881 Lafayette
1938 Ribner, Harold, 928 Lafayette
1918 Roberts, Edward Russell, 144 Golden Hill
1913 Roche, Thomas Joseph, 1815 Noble Ave.
1936 Rockwell, Alice Elizabeth, 1775 Noble Ave.
1944 Rosenberg, Hans August, 1621 East Main
1946 Rosenberg, Saul, 1950 Park Ave.
1946 Rosner, Fred, 1166 Fairfield Ave.
1947 Rudnick, Charles J., 42 Yale
1948 Russo, Robert Dante, 10 Washington Ave.
1942 Scalzi, Leonard Conrad, 924 Noble Ave.
1946 Schopick, Louis E., 2090 North Ave.
1943 Sciortino, Michael Vincent, 2072 North Ave.
1947 Scully, Michael Richard, 3265 Main
1928 Sekerak, Arthur Joseph, 408 Barnum Ave.
1938 Sekerak, Raymond Andrew, 1400 East Main
1938 Sekerak, Richard John, 938 East Main
1938 Shea, Cornelius Joseph, 1153 Park Ave.
1913 Shea, John Francis, 144 Golden Hill
1946 Sheiman, Milton, 1539 Park Ave.
1946 Sheiman, Samuel Charles, 1539 Park Ave.
1947 Sherman, Benjamin, 175 Brooklawn Ave.
1947 Sherman, Irving J., 1278 East Main
1944 Sholler, Nicholas A., 2148 North Ave.
1947 Siege, Alfred Geoffrey, 881 Lafayette
1939 Simses, John Peter, 144 Golden Hill
1935 Smith, Joseph Jacob, 1280 Stratfield Rd.
1919 Smith, Stanton Reinhart, 144 Golden Hill
1913 Smykowski, Bronislaw Louis, 405 Barnum Ave.
1930 Sollosy, Alexander, 1430 Fairfield Ave.
1941 Spinelli, Nicholas Victor, 1285 Noble Ave.
1909 Sprague, Charles Harry, 29 Hanover
1935 Strayer, Luther Milton, Jr., 144 Golden Hill
1940 Tarasovic, Thomas Joseph, 123 Churchill Rd.
1920 Taylor, Clifton Clark, 881 Lafayette
1938 Ter Kuile, Roger Couvelle, 881 Lafayette
1925 Tolk, Nathan Robert, 558 Clinton Ave.
1942 Trautman, Edwin Frederick, 5367 Main
1929 Turchik, Frank, 1831 Barnum Ave.
1947 Turetsky, Samuel, 2718 Fairfield Ave.
1941 Tutles, Alexander James, 860 Clinton Ave.
1943 Unger, Milton, 1025 Central Ave.
1932 Uvitsky, Irving Harry, 3101 Main
1947 Veneruso, Leonard Charles, 1690 Barnum Ave.
1941 Vioni, R. Edward, 3450 Main

1948 Walzer, Eugene Harold, 10 Washington Ave.
1942 Ward, James P., 881 Lafayette
1903 Warner, George Howell, 144 Golden Hill
1920 Watts, Joseph Francis, 881 Lafayette
1913 Weadon, W. Lee, 144 Golden Hill
1934 Wehger, Roland Theodore, 144 Golden Hill
1922 Weise, Ellwood Carl, 144 Golden Hill
1947 Yasser, Isidore, 1302 Stratford Ave.
1936 Yeager, C. Frederick, 2139 East Main
1935 Zaur, Israel Sidney, 881 Lafayette
1946 Zavadier, Nathan, 68 Ocean Ave.
1947 Zielinski, John Blaise, 562 Boston Ave.
1943 Zsiga, Elmo Douglas, 303 Clinton Ave.

DANBURY

1929 Amos, Isadore Louis, 323 Main
1929 Booth, John Dibble, 173 Main
1941 Brochu, Eugene Dalva, 229 Main
1902 Bronson, William Thaddeus, 41 West
1947 Burnie, George A., 105 Main
1942 DeKlyn, Ward B., 177 Main
1928 Delohery, Cornelius Leo, 65 Main
1935 Driscoll, Jerome James, 345 Main
1937 Eckert, George Robert, 394 Main
1947 Edson, Dean Harding, 75 West
1947 Epstein, Benjamin, 8 Locust Ave.
1935 Fox, Robert Adolph, 95 Locust Ave.
1931 Gaffney, John James, 265 Main
1931 Genovese, Frank Thomas, 172 White
1938 Genovese, Serafino, 390 Main
1930 Gibson, Donald Farnham, 75 West
1929 Goldys, Frank Max, 209 Main
1947 Gonzalez, Luis D., 27 Osborne
1897 Gordon, William Francis, 26 West
1940 Howard, Leonard Arnold, 87 West
1946 Lipton, Harold, 8 West
1948 McIlroy, Patrick Thomas, Danbury Hospital
1912 Mullins, Samuel Frederick, 116 Main
1937 Murphy, James Joseph, 147 Main
1939 Murray, Thomas Oscar, 75 West
1937 Rogol, Louis, 85 West
1947 Ruiz, Rolando R., 246 Main
1926 Selleck, Nathaniel Benedict, 215 Main
1913 Smith, Arthur Charles, 246 Main
1920 Stahl, William Martin, 343 Main
1947 Stahl, William Martin, Jr., 343 Main
1907 Sunderland, Paul Ulysses, 160 Deer Hill Ave.
1929 Sunderland, William Alexander, 158 Deer Hill Ave.
1932 Tomaino, Felix Francis, 8 West
1943 Weiner, William, Danbury Hospital
1947 Yoburn, Michael Myer, 65 West

DARIEN

1948 Coffin, S. Farnum, Jr., Hollow Tree and Middlesex Rds.
1944 Huntington, Frederic Sargent, Middlesex and Hollow Tree Ridge Rd.
1948 Lane, Warren Zeph, 160 Post Rd.
1941 Moore, Gilbert Emerson, 178 Post Rd.
1940 Ross, Allan Maxwell, 188 Post Rd.
1938 Van Tassel, Walter, 160 Post Rd.
1946 Voris, Jacques Van Brunt, 22 Old King's Hwy.

FAIRFIELD

1944 Barker, Daniel C., 133 Reef Rd.
1939 Biehn, Donald M. Frick, 1275 Post Rd.
1928 Biehn, Sidney Lister, 22 Reef Rd.
1946 Conner, Edward Dew, 1330 Post Rd.
1935 Davis, Thomas Francis, 1583 Post Rd.
1947 Grimm, Homer Willard, 413 Mill Hill Ter.
1944 Harris, H. Patterson, Jr., 1432 Post Rd.
1947 Joslin, Stuart L., 27 Unquowa Rd.
1948 Kemp, Edward P., 178 Reef Rd.

GREENWICH

1940 Adams, Mary, 149 Field Point Rd.
1935 Amoss, Harold Lindsey, 68 Deerfield Dr.
1939 Anderson, Clifton Winthrop, 116 East Elm
1948 Bullen, Benjamin Wells, Jr., 149 Field Point Rd.
1938 Carter, Gray, 29 Hillside Dr.
1943 Claps, Ludovic Vincent, 161 Mason
1933 Close, John Frederick, 66 Millbank Ave.
1944 Davol, Rector Thomson, 63 North
1947 Derkach, Stephen L., 36 Mason
1945 Fisher, Joseph G., Ituri Towers
1945 Gratz, Charles Murray, 40 West Elm
1940 Grigas, John E., 56 East Elm
1942 Halloran, James Vincent, 43 Lexington Ave.
1947 Hansell, Robert Joseph, 45 East Putnam Ave.
1937 Hawthorne, Julian, Greenwich Towers
1948 Intrieve, Anthony Donald, 18 Field Point Rd.
1944 Kelemen, Eugene, 1 West Elm
1927 Knapp, Charles Stanley, 18 Field Point Rd.
1940 Larimore, Louise D., 100 Lake Ave.
1933 Lockwood, Jane, 271 Lake Ave.
1930 Miller, John, 63 North
1941 Morris, Joyce Stringer, Greenwich Hospital
1944 Morrissett, Leslie Emerson, 261 Lake Ave.
1924 O'Donnell, Thomas James, 224 Milbank
1939 Reynolds, Whitman Mead, 30 Maher Ave.
1935 Rogers, Robert Page, 111 North
1946 Rourke, Thomas Alfred, 161 Mason
1938 Serrell, Howard P., 43 Maple Ave.
1940 Shaw, Lillian Eloise, 45 Field Point Rd.
1943 Squier, Raymond R., 40 West Elm
1940 Swarts, William B., Warwick Towers
1937 Thompson, Sidney Attilio, 161 Mason
1940 Tiebout, Harry Morgan, Blythewood
1934 Tinkess, Donald Ewing, Stanwich Rd.
1939 Tunick, George L., 193 Mason
1933 Vickers, J. Leonard, 40 West Elm
1942 Weber, Frederick Clarence, Jr., 92 Mason
1947 Wright, Harold S., 18 Field Point Rd.

Cos Cob

1940 Ayres, Payson Bryan, 10 Old Post Rd.
1912 Bergin, Thomas Joseph, 2 Mead Ave.
1940 Bria, William Francis, 525 East Putnam Ave.
1948 Levine, Abraham I., 3 Strickland Rd.

Old Greenwich

1926 Kaprielian, H. Kruger, 312 South Beach Ave.
1936 Kelly, J. Colman, 30 Highview Ave.
1948 Raffaele, Frank Joseph, Binney Lane
1939 Read, Francis Arnold, 292 Sound Beach Ave.
1929 Shermak, Joseph V., 13 Arcadia Rd.

MONROE

Stepney Depot

1912 Wales, Francis Joseph
1946 Williams, Francis Pryor Anthony

NEW CANAAN

1937 Abrahams, Meyer, 191 South
1939 Cammann, Oswald DeNormandie, Oenoke Ave.

1941 Cody, Thomas Patrick, 222 South Main
1938 DuBois, Franklin Smith, Silver Hill
1939 Frothingham, John Gerrish, 149 South Main
1941 Hebard, George Whiting, Elm
1945 Hiden, Robert Battaile, Silver Hill
1935 Ludlow, George Craig, 8 Oenoke Ave.
1945 Pearce, Marvin Ghent, Silver Hill
1935 Terhune, William Barclay, Silver Hill
1941 Twachtman, Eric, 28 Elm
1931 Wadsworth, Ruth Flanigen, Smith Ridge
1944 White, Ralph L., 178 South Main

NEWTOWN

1934 Clow, Henry Leon, Fairfield State Hospital
1927 Desmond, Waldo Fairfield, Main
1947 Ducker, Stuart R., Fairfield State Hospital
1937 Egee, J. Benton
1941 Friedman, Samuel, Fairfield State Hospital
1940 Green, William Frederick, Fairfield State Hospital
1947 Kyle, George Byron, Glen Rd., Sandy Hook
1918 Knapp, Charles W., Taunton Rd., R. F. D. No. 1
1941 Oltman, Jane Elizabeth, Fairfield State Hospital
1947 Stephens, Duncan C., Fairfield State Hospital

NORWALK

1942 Bradley, E. Tremain, 15 Beldin Ave.
1933 Bucciarelli, John Anthony, 520 West Ave.
1945 Corwin, Daniel Bernard, 463 West Ave.
1937 Diamond, Edward H., 15 Belden Ave.
1940 Fitzpatrick, Wesley Fenton, 85 East Ave.
1946 Gens, John Paul, 64 Wall
1947 Genvert, Harold, 75 East Ave.
1938 Gorham, Grace Viola, 64 Wall
1948 Ippolito, Thomas Leonard, 75 East Ave.
1945 Johnson, William Henry Nelson, Jr., 14 Leonard
1915 Kellogg, Henry Kirke White, 725 West Ave.
1946 Mills, Clifford Wheeler, 65 East Ave.
1938 Northrop, Robert Arthur, 64 Wall
1947 Ogden, Faith Newbury, 6 Stevens
1938 Padula, Ralph Domenick, 84 West Ave.
1929 Patterson, Frederick Arthur, 520 West Ave.
1942 Paul, Francis, 64 Wall
1930 Perkins, Charles Winfield, 520 West Ave.
1920 Perry, Mabelle Jeane, 676 West Ave.
1938 Piasecki, Joseph L., 520 West Ave.
1928 Scanlon, Thomas Francis, 394 West Ave.
1941 Shain, Joseph H., 520 West Ave.
1929 Tracey, Edward John, 637 West Ave.
1890 Tracey, William Joseph, 637 West Ave.
1938 Vollmer, John William, 654 West Ave.
1934 Wallace, Victor George Henry, 55 Wall
1938 Weinstein, Nathan, 471 West Ave.
1943 Willis, Thayer, Bettswood Rd.

South Norwalk

1936 Beck, Eugene Cornelius, 75 South Main
1946 Burack, Jason Oliver, 3 West Ave.
1941 Cody, George Richard, 61 South Main
1938 Corridon, James Donald, 119 West Ave.
1943 Davis, James Sumner, 59 South Main
1922 Fawcett, George Gifford, 8 Washington
1941 Flanagan, Edwin Daniel, 141 West Ave.
1938 Giuliano, Louis Augustine, 84 West Ave.
1941 Green, H. Howard, 75 South Main
1940 Heafey, John Robert, 84 West Ave.
1938 Hunkemeier, Edna, 3 Washington
1938 Keys, Robert Cathcart, 84 West Ave. and 322 Main, Stamford
1948 Margold, Allen Montague, 84 West Ave.
1941 McMahon, John David, 4 Washington
1923 McMahon, William Henry, Jr., 13 Washington
1938 Paris, Marcus, 34 West Ave.
1941 Rosenthal, Isidor, 72 South Main
1947 Rubin, David, 38 West Ave.
1939 Scanlon, John Joseph, 276 West Ave.
1947 Serena, Frank A., 84 West Ave.
1946 Serena, John Mario, 84 West Ave.
1931 Simon, Louis Goodwin, 30 West Ave.
1943 Steinberger, Lazslo, 96 South Main
1937 Stietzel, Eric Ernst, 5 Washington

REDDING

1941 Grevatt, Kenneth Lloyd

RIDGEFIELD

1937 Bell, Joseph Sloane, 54 Main
1947 Burgess, Forbes Hathaway, 126 Main
1944 Inkster, James Henry, 153 Main
1946 Pease, Marshall Carleton, Branchville Rd.
1927 Woodford, Francis Bowditch, 62 Main

RIVERSIDE

1945 Meeker, D. Olan, Riverside Ave.

SHELTON

1945 Burns, Francis Michael, 499 Howe Ave.
1939 Edson, Ralph Howard, 77 Oak Ave.
1917 Finn, Edward James, 452 Howe Ave.
1930 Gaetz, Thomas Harold, Laurel Heights
1937 Howlett, Kirby Smith, Jr., Laurel Heights
1925 Lynch, Edward James, Laurel Heights
1941 Pagliaro, Joseph John, 433 Howe Ave.
1895 Randall, William Sherman, 241 Coram Ave.

SOUTHPORT

1947 Sterrett, Raymond A., 115 Main

SPRINGDALE

1948 Pappenheim, Else, 33 Palmer

STAMFORD

1937 Aldwin, Francis Joseph, 295 Atlantic
1936 Bannon, Frederick Michael, 300 Main
1947 Barber, Richard Robbins, 77 Bedford
1907 Barnes, Frank Haslehurst, Dr. Barnes Sanitarium
1947 Beaman, G. Burnham, 322 Main
1927 Bissell, Addison Hayes, 65 South
1944 Blass, Gustaf, Stamford Hall
1948 Boshnack, Malcolm, 70 Strawberry Hill Ave.
1926 Bowman, Stuart Howard, 65 South
1928 Brown, Paul Hemingway, 140 Woodside Village
1935 Carpenter, Robert Morse, 636 Summer
1937 Carwin, Joseph Lucian, Jr., 115 West Main
1944 Cassone, Rocco, 308 Atlantic
1946 Chaucer, Norton G., 1937 West Main
1947 Choutzu, Pei, 197 Main
1947 Cognetta, Armond B., 25 Bedford
1940 Cognetta, James John, 228 West Broad
1946 Colburn, Russell Fitch, 1416 Bedford
1942 Colmers, Rudolph Albert, 295 Atlantic
1940 Connolly, Joseph Patrick, 104 South
1937 Costanzo, James Joseph, 300 Main
1940 Crane, James Everett, 50 Glenbrook Rd.
1909 Crane, Ralph William, 50 Glenbrook Rd.
1937 Cunningham, Robert D. M., 65 South

1934 D'Andrea, Frank Henry, 29 South
1947 Davis, Jeff, 76 Glenbrook Rd.
1938 Dean, Stanley Rochelle, 94 Prospect
1909 Dichter, Charles Levi, 33 Forest
1935 Dichter, Irving Samuel, 33 Forest
1947 DiFrancesco, Lindo Peter, 65 South
1947 Dobkins, John Jacob, 81 Atlantic
1937 Dorion, Robinson Harry, 610 Summer
1947 Felding, Howard Anthony, 300 Main
1933 Fincke, C. Louis, 1 Atlantic
1937 Fine, Barnet, 70 Grove
1936 Fine, Joseph, 55 Forest Rd.
1931 Fiske, Madeline, 77 Bedford
1948 Fogel, David Hudson, 1380 Bedford
1934 Friedberg, Solomon, 671 Bedford
1931 Gandy, R. Alfred, 65 South
1913 Gandy, Raymond Reeves, 65 South
1931 Giles, Newell Walton, 1 Atlantic
1945 Greenblatt, Jacob, 67 Forest
1947 Haine, John W., 636 Summer
1937 Harrison, Francis Murphy, 512 Atlantic
1908 Harrison, John Francis, 512 Atlantic
1916 Henderson, Alfred Collard, 55 Glenbrook Rd.
1930 Hertzberg, Reinhold Frederick, 60 Glenbrook Rd.
1937 Hymovich, Leo, 1521 Summer
1944 Jaiven, Saul Joseph, 1521 Summer
1929 Keddy, Russell Alfred, Stamford Hospital
1938 Kezel, Albert Patrick, 188 Grayrock Pl.
1947 Klein, Harold T., 578 Summer
1939 Koffler, Arthur, 90 Glenbrook Rd.
1947 Leong, Ellen Fooklen, 197 Main
1948 MacKee, George Miller, Haviland Rd.
1934 Malloy, Edward Francis, 65 South
1948 Mancinelli, M. Joseph, 50 Division
1946 Mastrangelo, Angelo, Jr., 29 South
1933 McFarland, Frederick William, 65 South
1928 McGourty, Andrew Frederick, 7 Glenbrook Rd.
1935 McGourty, David Philip, 95 Hope
1924 McMahon, Frank Cash, 62 Suburban Ave.
1947 Meacham, Charles Thomas, 65 South
1930 Meschter, Eugene Funk, Yale & Towne Mfg. Co.
1946 Miller, Hugh Kennedy, 970 Summer
1936 Moore, Clifford Douglas, Stamford Hall
1947 Mulaire, Victor J., 65 South
1938 Murphy, Charles Anthony, 59 South
1931 Murray, Henry Joseph, 53 South
1940 Nemoitin, Bernard Oscar, 96 Main
1911 Nemoitin, Jacob, 96 Main
1946 Ogilvie, John Black, 610 Summer
1938 O'Meara, Francis Patrick, 1 Elm Pl.
1946 Paley, I. Martin, 322 Main
1928 Paul, Voyle Abrams, 65 South
1946 Poczabut, John Stephen, 65 South
1938 Rawls, Cotton, 300 Main
1929 Resnik, William Harry, 65 South
1942 Robison, Roy Calvin, 65 South
1936 Rose, Samuel Allison, 65 South
1943 Ryder, Clifford Fuller, 77 Bedford
1929 Rynard, William Morvel Wesley, 50 Division
1946 Sabia, Daniel Joseph, 65 South
1932 Schmidt, Norman Louis, 60 Glenbrook Rd.
1930 Sette, Alfred Joseph, 78 Forest
1938 Sherman, Saul Harvey, 328 Atlantic
1941 Smith, Leo Michael, 65 South
1917 Smith, William Earl, 65 South
1947 Snaveley, John Geoffrey, Stamford Hospital
1942 Stankard, William Francis, 140 Forest
1934 Starrett, Jay Ellis, 970 Summer
1907 Staub, J. Howard, 100 South
1931 Stone, Merlin Jones, 76 Glenbrook Rd., also 16 Mason, Greenwich
1920 Stringfield, Oliver Linwood, 1416 Bedford
1940 Troy, William Daniel, 612 Bedford
1931 Turnley, William Henry, 1 Atlantic
1939 Washburn, Wendell James, 65 South, and 261 Lake Ave., Greenwich
1947 White, William B., 805 Gurley Bldg.
1947 Wrona, Eugene Adam, 229 South

STRATFORD

1947 Anton, Michael Charles, 2390 Main
1938 Ashcroft, Allan Davis, 3585 Main
1947 Brown, Richard J., 2220 Main
1945 Buda, Gaza Edward, 2362 Main
1943 Dinan, H. Philip, 3466 Main
1897 Fleck, Harry Willard, 1 Pauline St., Lordship
1936 Friedman, Nathan Harris, 2336 Main
1927 Haberlin, Chester Edward, 2944 Main
1939 Levy, Samuel Howard, 3007 Main
1934 Maher, John Rodden, 2184 Main
1931 Oesau, Harold Thomas, 1949 Main
1940 Penner, Sidney Lincoln, 2692 Main
1942 Roberge, George Edward, 44 Plymouth
1937 Strayer, Estella Morton, Lordship Rd.
1942 Thomases, Saul, 2595 Main

TRUMBULL

Long Hill

1946 Corbett, William Tihamer, Box 158
1912 Smith, George Arthur

WESTPORT

1947 DiBlanda, Harry A., 10 Taylor Pl.
1930 Ellrich, David Lionel, 125 East State
1943 Gerow, George H., Westport Sanitarium
1943 Hart, J. Garwood, 67 Myrtle Ave.
1943 Houze, Harry G., Westport Sanitarium
1946 Isenman, Robert, 26 West State
1947 Lebhar, Neil F., Bay St.
1934 Morgan, William Oliver, 193 Main
1937 Nespor, Robert Wenzel, 10 Taylor Pl.
1925 Phillips, Harry Shaw, 44 Church Lane
1941 Shoup, Homer B., Jr., 58 East State St.
1934 Smith, Stephen Munro, 78 Main
1943 Solway, Reuben Isaac H., 450 Kings Highway
1936 Teuscher, William Philip, 18 Compo Rd.

WILTON

1939 Knauth, Marjorie Strauss, Drum Hill Rd.
1944 McCombs, A. Parks, Hurlbutt

OUT OF COUNTY

1941 Benton, Philip Eglin, 144 West High, Mt. Gilead Ohio
1945 Bliss, Sheldon Pratt, Chance Vought Aircraft, P. O. Box 5907, Dallas, Texas
1939 Brewer, Francis, 860 Park Ave., Bloomfield
1943 Cacace, Vincent Anthony, 4251 Shamrock Ave., Baltimore, Md.
1948 Conway, Herbert, 525 East 68th, New York
1937 Craighill, Margaret D., 1209 Collins Ave., Topeka, Kansas
1935 Grout, Stillman Proctor, East Dorset, Vermont
1929 Hamilton, John S. M., Fitzsimons General Hospital, Denver, Colo.
1937 Harper, Paul, 21 Elmwood Rd., Baltimore, Md.

1937 Hopper, Edward Bernard, Brooklyn Naval Hospital, Brooklyn, N. Y.
1938 Hurlburt, Edward G., "F" Ave., Coronado, Calif.
1939 Ireland, Richard Milton, 66 Bridge, New Milford
1939 Keating, John Joseph, 22 Elm, New Milford
1941 Kennedy, Robert Edward, Veterans Administration Hospital, Roanoke, Va.
1941 Knepp, James Warren, 95 Pearl, Hartford
1913 Lambert, H. Bertram, Veterans Hospital, Rocky Hill
1907 Pratt, Nathan Tolles, Old Saybrook
1943 Robey, Nathaniel Charles, Toledo State Hospital, Toledo, Ohio
1909 Shirk, Samuel Martin, Masonic Home, Wallingford
1920 Tracey, William Wallace, Lauderdale County Health Dept., Meridian, Mississippi
1942 Upham, Charles E. H., 5 Prospect, New Rochelle, New York
1942 Yohn, Albert Klamroth, 1659 34th, N.W., Washington, D. C.

Hartford County Association

President: Charles T. Schechtman, 81 West Main, New Britain
Vice-President: Harvey B. Goddard, 970 Main, East Hartford
Secretary-Treasurer: W. Holbrook Lowell, 703 Asylum Ave., Hartford
Councilor: C. Charles Burlingame, 200 Retreat Ave., Hartford
Business Office: 38 Prospect St., Hartford

Annual Meeting, First Tuesday in April
Semi-Annual Meeting, Fourth Tuesday in October

AVON

1941 Wiepert, William Murray, Main

BERLIN

1947 Foster, Hollis Joseph, Worthington Ridge
1908 Hodgson, Thomas Cady, Worthington Ridge

BLOOMFIELD

1936 Burgdorf, Alfred Louis, Duncaster Rd.
1905 Clifton, Harry Coltman, Simsbury Rd.
1905 Swett, Paul Plummer, Gun Mill Rd.

BRISTOL

1930 Appell, Paul Harry, 227 Main
1943 Barton, Preston Nichols, New Departure Corp.
1934 Beatrice, Alphonse Anthony, 331 Main
1936 Bird, Frederick Stanford, 124 Main
1932 Borkowski, Boleslaus Joseph, 4 School
1900 Brackett, Arthur Stone, 321 Main
1947 Brezina, Philip Savage, 308 Main
1948 Brockway, Dorothy W., 153 Federal
1946 Ciccarelli, Armanno William, 481 North Main
1948 Claffey, Michael F., 81 Main
1947 Czyz, Stanley Ignacy, 257 Main
1947 Dalmain, Walter Andrew, 72 North Main
1934 Donohue, Bartholomew Francis, 481 North Main
1935 Flynn, William Henry, 9 North Main
1947 Furniss. William Ernest, 239 Belridge Rd.
1937 Hall, Martin Irving, 19 High
1946 Hanley, J. Bainbridge, 63 Bellevue Ave.
1921 Hanrahan, William Richard, 209 Center
1938 Hudon, Frederick Alfred, 321 Main
1939 Labuz, Eugene Frank, 342 Main
1928 LaPlume, Albert Antonio, 45 Prospect
1942 Littwin, Ralph J., 19 High
1929 Nestos, Peter Alexander, 63 Main
1935 Papa, John Smith, 124 Main
1921 Park, Paul Archibald, 133 Main
1921 Richardson, Ralph Augustus, 4 School
1935 Siliciano, Raoul Andrew Victorius, 110 South
1936 Stevenson, William Robb, 124 Main
1939 Tirella, Fred Francis, 249 Main
1942 Vogel, Frank Siegfried, 301 Main
1909 Whipple, Benedict Nolasco, 45 North Main
1934 Winters, Hyman W., 405 North Main
1914 Woodward, Harold Burton, 321 Main

CANTON

Collinsville

1906 Cox, Ralph Benjamin

EAST HARTFORD

1945 Carignan, Roland Zephirin, 74 Connecticut Blvd.
1944 Curtis, Alton Kallock, 5 Broad
1936 Gallivan, John Norman, 74 Connecticut Blvd.
1927 Goddard, Harvey Burton, 970 Main
1923 Haylett, Howard Bulkeley, 1109 Main
1946 Hervey, Zoltan P., 1169 Main
1933 Houle, Raymond Theodore, 5 Central Ave.
1934 Lublin, Raymond David, 759 Main
1937 McCue, Martin Patrick, 1617 Main
1939 Mirabile, Thomas Joseph, 59 Burnside Ave.
1947 Murphy, John Joseph, 27 Wells Ave.
1916 Onderdonk, Harrie Jay, 11 Central Ave.
1920 Schaefer, Jacob, 1011 Main
1948 Seigle, Stewart Pinnell, 1169 Main
1948 Swett, Norris Poole, 970 Main
1942 Trantolo, Arthur, 1559 Main
1912 Truex, Edward Hamilton, 163 High

EAST WINDSOR

Broad Brook

1923 Robinson, Wilford John Thomas, Main

Warehouse Point

1937 Maslak, Rudolph, South Main

ENFIELD

1943 Yerbury, Charles Calvin, 1070 Enfield

Hazardville

1906 Bridge, John Law, P. O. Box 272
1923 Shepherd, William Gordon, Main

Thompsonville

1937 Bloom, David Irving, 126 Pearl
1937 Dignam, Bernard Stephen, 133 Pearl
1938 Gourlie, Howard Wallace, 75 North Main
1917 Vail, Thornton Edwin, 124 Main
1940 Valenski, Thaddeus James, Main

FARMINGTON

1946 Barbour, Paul Humphrey, Jr., High
1933 Bunnell, Walls Willard, Main
1935 MacLean, Ethel Margaret, High

GLASTONBURY

1933 Earle, Benjamin Baylis, 2458 Main
1935 Griswold, Edwin Monroe, 2858 Main
1943 Pharris, Crit, 1252 Main
1939 Raffa, Joseph, 2638 Main
1946 Ricca, Renato A., 28 Ripley Rd.
1924 Whittles, Lee Jay, 2205 Main

South Glastonbury

1908 Ward, James W., 972 Main

HARTFORD

1942 Allen, George Francis, 179 Allyn
1944 Allen, Mary Mazner, 179 Allyn
1927 Allen, Wilmar Mason, 20 South Hudson
1937 Andrews, Egbert Morrill, 576 Farmington Ave.
1927 Antupit, Louis, 242 Trumbull
1936 Apter, Harry, 1453 Main
1932 Arons, Milton Robert, 750 Main
1904 Backus, Harold Simeon, 99 Pratt
1913 Bailey, N. Herbert, 550 Main
1923 Bancroft, Harold Arthur, 179 Allyn
1947 Barbour, Charles Manson, Jr., 20 South Hudson
1940 Barker, Norman John, 55 Elm
1933 Bausch, Carl Philipp, 36 Pearl
1907 Beach, Charles Thomas, 50 Farmington Ave.
1929 Beatman, Israel, 242 Trumbull
1948 Beckett, Ronald Stewart, 559 Hudson
1944 Beebe, John Taylor, 665 Asylum Ave.
1934 Beizer, Edmund, 44 Garden
1947 Bernstein, Louis, 179 Allyn
1923 Bestor, Eugene Leonard, 36 Pearl
1926 Bidgood, Charles Young, 247 South Whitney
1936 Bingham, Charles Tiffany, 576 Farmington Ave.
1938 Birge, Henry L., 179 Allyn
1941 Bobrow, Aaron, 387 Blue Hills Ave.
1897 Botsford, Charles Porter, 219 Collins
1941 Brandon, Kenneth Francis, 151 Farmington Ave.
1916 Branon, Anthony William, 179 Allyn
1912 Brayton, Howard Wheaton, 179 Allyn
1931 Brecker, F. Wellington, 955 Asylum Ave.
1939 Brennan, Edward L., 50 Farmington Ave.
1931 Brewer, Timothy Francis, 50 Farmington Ave.
1946 Brewster, William B., Jr., 179 Allyn
1943 Browne, Florence A., 436 Capitol Ave.
1942 Bruskin, Chaim Elias, 1840 Park
1929 Buck, Burdette Jay, 299 Farmington Ave.
1931 Buckley, Richard Cotter, 50 Farmington Ave.
1932 Burlingame, Clarence Charles, 200 Retreat Ave.
1946 Burness, Sidney Harold, 99 Pratt
1928 Butler, Nicholas George, 50 Farmington Ave.
1930 Byrne, David Walter, 179 Allyn
1942 Cabaniss, Joseph Turner, 700 Main
1931 Calverley, Eleanor Jane Taylor, 143 Sigourney
1934 Cappiello, Silvestro, 97 Vine
1948 Carangelo, John, 402 Farmington Ave.
1933 Carey, Thomas Cornelius, 50 Farmington Ave.
1931 Carniglia, Ettore Francis, 50 Farmington Ave.
1929 Carroll, James Edward, 220 Farmington Ave.
1915 Carter, Earl Buell, 99 Pratt
1937 Case-Downer, Muriel, 157 Warrenton Ave.
1930 Caulfield, Ernest Joseph, 683 Asylum Ave.
1933 Cenci, Vincent Peter, 50 Farmington Ave.
1943 Chester, Lewis L., 179 Allyn
1940 Clancy, John James, 179 Allyn
1935 Clarke, Ralph deBallard, Cedarcrest
1922 Clason, Freeman Pell, 179 Allyn
1937 Clifford, Martha Louise, 436 Captiol Ave.
1931 Climan, Max, 242 Trumbull
1928 Cogan, George Eugene, 50 Farmington Ave.
1913 Cogswell, Eliot Sanborn, 179 Allyn
1936 Cogswell, Lawrence Perley, 179 Allyn
1938 Cohn, Samuel Hills, 464 Farmington Ave.
1948 Cole, Milton Julius, 75 Pratt
1935 Connor, Joseph Joyce, 750 Main
1933 Corcoran, Michael Anthony, 689 Asylum Ave.
1946 Cornwell, Philip Morba, 179 Allyn
1913 Costello, Henry Nicholas, 124 Beacon
1944 Cramer, Sidney Leo, 64 Garden
1933 Crosby, Edward Harding, 50 Farmington Ave.
1941 Cullen, James Rescott, 74 Farmington Ave.
1936 Cunningham, James Morrow, 165 Capitol Ave.
1946 Curran, Timothy Leonard, 689 Asylum Ave.
1938 Curtis, Burr Harding, 4 Atwood
1914 Daly, Charles William, 247 South Whitney
1935 Daly, William Patrick, 342 Edgewood
1929 Davenport, Anna Keith Prentiss, 50 Wethersfield A
1922 Davis, James Edward, 16 Sunny Reach Dr.
1909 DeBonis, Domenico A., 183 Westland
1946 Delligan, Francis William, 114 Woodland
1947 Deming, Archibald Staley, 715 Asylum Ave.
1914 Deming, Clinton Demas, 179 Allyn
1914 Deming, Edward Adams, 715 Asylum Ave.
1931 DePasquale, Francis Lawrence, 1992 Broad
1937 DePasquale, John Anthony, 54 Church
1946 Desmond, Charles Thomas, 683 Asylum Ave.
1934 DeVito, Michael Joseph, 525 Main
1931 Dion, Asa Joseph, 207 Washington
1944 Dion, Julien Andre, 207 Washington
1939 Dodd, Burwell, 293 Farmington Ave.
1944 Doerr, William John, 80 Farmington Ave.
1948 Donnelly, William Allen, 689 Asylum Ave.
1934 Donner, Samuel, 99 Pratt
1938 Donovan, William Francis, 47 Main
1947 Dressler, Morris, 282 Laurel
1937 Duffy, Leo Thomas, 683 Asylum Ave.
1942 Duksa, Walter Joseph, 535 Main
1938 Durkee, Ralph Everett, Jr., 179 Allyn
1946 Dushane, Joseph Edward, 147 Sigourney
1916 Dwyer, William, 18 Asylum
1947 Ebers, Theodore Martin, 140 Garden
1927 Elliot, K. Gregory, 631 Park
1943 Ellis, Lyle Gaffney, 700 Main
1948 Ellis, William Avery, 945 Asylum Ave.
1937 Ellison, Frederick Speirs, 50 Farmington Ave.
1914 Emmett, Francis Arthur, 410 Asylum
1946 Englehart, Ernest Erwyn, 21 Marshall
1937 Fagan, Francis Xavier, 683 Asylum Ave.
1933 Farland, Victor Louis, 54 Pratt
1947 Farmer, Joseph Arthur, 200 Retreat Ave.
1948 Fay, Kevin John, Underwood Corp., Capitol Ave.
1919 Fay, William James, 179 Allyn
1941 Feeney, Thomas Michael, 701 Asylum Ave.
1929 Felty, Augustus R., 50 Farmington Ave.
1942 Finesilver, Edward Max, 410 Asylum
1934 Finley, George Clark, 50 Farmington Ave.
1913 Flaherty, Claude Vincent, 50 Farmington Ave.
1943 Fleish, Milton Carl, 64 Garden
1947 Fortier, Norman Lionel, 99 Pratt
1943 Fox, George Francis, 1174 Main
1925 Fox, James Charles, Jr., 56 Garden
1947 Franco, John Estrela, 955 Asylum Ave.
1931 Friery, Clarence Milton, 110 Greenfield
1943 Fritz, John, 656 Park
1919 Furniss, Henry Watson, 1337 Main
1927 Gaberman, David, 179 Allyn

1947 Gaines, Nemo Dexter, 700 Main
1937 Galinsky, David, 57 Wethersfield Ave.
1946 Gardy, Lawrence Andrew, 1731 Park
1921 Garland, Robert Bernard, 689 Asylum Ave.
1931 Geetter, Isador Stolper, Mt. Sinai Hospital
1941 Gibson, Forrest Davis, 701 Asylum Ave.
1946 Giffin, Lewis Albee, 179 Allyn
1898 Gill, Michael Henry, 36 Pearl
1941 Gillespie, Harry, 983 Main
1922 Gills, William Lee, 179 Allyn
1934 Giorgio, Nicholas Anthony, 61 Edwards
1937 Giuliano, Sebastian, 468 Franklin Ave.
1935 Glass, George Courtenay, 576 Farmington Ave.
1943 Glass, William Henry, 11 Asylum
1934 Glaubman, Henry Mitchell, 20 Lenox
1946 Godfrey, Ellwood Watson, 179 Allyn
1927 Goff, Charles Weer, 30 Farmington Ave.
1936 Gold, Louis Henry, 184 North Beacon
1930 Goldenberg, Jacob Joseph, 832 Albany Ave.
1947 Goldstein, Max Richard, 44 Garden
1946 Golino, Emanuel Francis, 635 Main
1944 Golston, Harry, 750 Main
1933 Goodell, Robert Alvan, 79 Elm
1940 Goodrich, William Albert, 179 Allyn
1919 Gosselin, George Adelor, 50 Farmington Ave.
1946 Gottesfeld, Benjamin Harvey, 99 Pratt
1935 Gould, Max Martin, 434 Main
1923 Grau, Leroy Charles, 700 Main
1939 Gray, Albert Stanley, 1179 Main
1938 Gray, Harry Joshua, 750 Main
1943 Greene, Gerald S., 179 Allyn
1924 Griswold, Matthew Hammond, 165 Capitol Ave.
1948 Gross, Harold Arnold, 16 Eastford
1941 Grossman, Walter, 242 Trumbull
1921 Grosvenor, Frank Livingston, 700 Main
1930 Hall, Llewellyn, 79 Elm
1939 Hall, Wendell Charles, 179 Allyn
1947 Hamlin, Charles H., 945 Asylum Ave.
1938 Harris, Louis David, 242 Trumbull
1936 Harvey, Daniel Foster, 218 North Beacon
1930 Hastings, Louis Pease, 114 Woodland
1937 Hazen, Donald Robert, 295 Farmington Ave.
1946 Hellijas, Carl Sylvester, 20 South Hudson
1931 Hennessy, James Joseph, 50 Farmington Ave.
1946 Hepburn, Robert Houghton, 179 Allyn
1907 Hepburn, Thomas Norval, 179 Allyn
1940 Heublein, Gilbert Whipple, 179 Allyn
1030 Heyman, Joseph, 410 Asylum
1934 Hirschfeld, Otto Max, 1037 Albany Ave.
1931 Hirshberg, Manuel Shelton, 135 Blue Hills Ave.
1925 Hoffman, Charles Curtis, 700 Main
1924 Hogan, Walter Louis, 750 Main
1929 Holt, Kerchival Rogers, 50 Farmington Ave.
1930 Holtz, Raymond Sidney, 7 Woodland
1945 Hopper, Jerome Murray, 50 Farmington Ave.
1948 Horton, William Hanson, 165 Capitol Ave.
1935 Hough, Perry Tyler, 178 Beacon
1922 Howe, Glover Elbridge, 576 Farmington Ave.
1936 Hurwitz, George Hillel, 99 Pratt
1917 Hutchison, James Elder, 665 Asylum Ave.
1937 Irving, James Grant, 151 Farmington Ave.
1939 Jackson, Allen Francis, 2137 Main
1944 Jacobson, Charles Edward, Jr., 50 Farmington Ave.
1934 James, Lewis Paul, 11 Asylum
1941 January, Derick Algernon, 179 Allyn
1942 January, Mildred Hartshorn, 111 Gillett
1912 Jarvis, H. Gildersleeve, 179 Allyn
1948 Jennings, Walter Forfar, 30 Farmington Ave.
1940 Jenovese, Joseph Francis, 179 Allyn
1941 Johnson, Paul, 179 Allyn
1930 Jones, Frank Stafford, 179 Allyn
1928 Kalin, Jacob Isaac, 725 Asylum Ave.
1933 Kardys, John Albert, 487 Main
1935 Karotkin, Robert Harold, 816 Albany Ave.
1945 Karpe, Richard, 801 Farmington Ave.
1935 Kaschmann, Joseph, 42 Asylum
1937 Katz, Dewey, 99 Pratt
1924 Katz, Henry, 750 Main
1941 Katzman, Samuel Sidney, 11 Asylum
1926 Keefe, George Gregory, 30 Sisson Ave.
1934 Keefe, Raymond Starkey, 272 Franklin Ave.
1934 Keefe, Walter Joseph, 350 Farmington Ave.
1920 Kelly, Claude Currie, 179 Allyn
1930 Kendall, Ralph Emerson, 20 South Hudson
1947 Kenney, William Edmond, 30 Farmington Ave.
1927 Kilbourn, Austin, 1039 Asylum Ave.
1920 Kilbourn, Joseph Birney, 36 Pearl
1946 Kirsch, Neville, 56 Garden
1932 Klein, Abraham Arthur, 139 Fern
1946 Klein, Joseph, 80 Farmington Ave.
1944 Krall, Irving Hadley, 99 Pratt
1930 Kunkel, F. Earle, 179 Allyn
1941 Lamoureux, Eugene Edward 165 Capitol Ave.
1901 Lampson, Edward Rutledge, 175 North Beacon
1938 Lampson, Rutledge Starr, 179 Allyn
1913 Landry, Arthur Bernard, 50 Farmington Ave.
1926 Landry, Benedict Bernard, 50 Farmington Ave.
1940 Lankin, Joseph John, 525 Main
1943 Lapenta, Rocco George, 1307 Albany Ave.
1929 Larrabee, John Whitfield, 64 Garden
1946 Larson, Albert Lloyd, 700 Main
1942 Lenehan, John Richard, 683 Asylum Ave.
1938 Leonard, John Charles, 20 South Hudson
1933 Levin, Albert Eliot, 242 Trumbull
1946 Levin, Robert Raphael, 99 Pratt
1935 Levine, Sinclair Simcha, 54 Church
1936 Lewis, Samuel Donald, 49 Pearl
1937 Lischner, Moses David, 75 Pearl
1946 Litter, Leo, 747 Asylum Ave.
1934 Little, Milton Frederick, 49 Pearl
1915 Locke, Harry Leslie Franklin, 179 Allyn
1941 Lowell, W. Holbrook, Jr., 703 Asylum Ave.
1923 Luby, Thomas John, 410 Asylum
1913 Madden, Leon Irving, 234 North Beacon
1919 Maislen, Samuel, 2138 Main
1931 Mancoll, Morris Max, 242 Trumbull
1943 Marinaro, Nicholas Anthony, Cedarcrest
1932 Marranzini, Samuel, 701 Asylum
1946 Martin, Stevens John, 114 Woodland
1948 Mastronarde, Nicholas Angelo, 701 Asylum Ave.
1930 McClellan, Wilbert Ernest, 75 Pearl
1936 McCormack, Christopher Joseph, 50 Farmington Ave.
1938 McCrann, Donald Joseph, 50 Farmington Ave.
1934 McDermott, John Francis, 750 Main
1933 McGrath, John Francis, 663 Maple Ave.
1934 McLean, John Joseph, 64 Garden
1932 McLellan, Philip Garretson, 297 Farmington Ave.
1935 McNulty, Terence Francis, 21 Sisson Ave.
1947 Merwin, Thomas Keery, 179 Allyn
1946 Messina, Michael C., 561 New Britain Ave.
1933 Middlebrook, Louis Francis, Jr., 293 Farmington Ave.
1937 Miller, Harry Bernard, 983 Main
1916 Miller, James Raglan, 179 Allyn
1947 Miller, Seymour M., 1711 Park
1933 Mirabile, Charles Samuel, 179 Allyn
1947 Moher, James J., 689 Asylum Ave.
1938 Montano, Charles Carl, 525 Main
1909 Morrissey, Michael Joseph, 18 Asylum

1929 Morse, Lyman Rogers, Cedarcrest
1927 Moylan, Thomas Patrick, 50 Farmington Ave.
1930 Moyle, Henry Brown, 79 Farmington Ave.
1942 Mulville, Maurice Francis, 689 Asylum Ave.
1897 Naylor, James Henry, 1 Main
1938 Neidlinger, William James, 576 Farmington Ave.
1946 Nichols, Edward, 576 Farmington Ave.
1947 Nichols, Frederick L., 179 Allyn
1948 Nolan, John O'Leary, 114 Woodland
1944 O'Connell, John Daniel, 50 Farmington Ave.
1923 O'Connell, John Francis, 865 Park
1928 O'Connell, Maurice Francis, 50 Farmington Ave.
1902 O'Flaherty, Ellen Pembroke, 140 Main
1928 Ogden, Ralph Trafton, 179 Allyn
1931 Olmstead, John Gerald Maurice, 404 Farmington Ave.
1937 O'Neil, Charles William, 18 Asylum
1921 Osborn, Stanley Hart, 165 Capitol Ave.
1927 Osmond, Robert Hunter, 50 Farmington Ave.
1938 Padula, Vincent Domenica, 1210 Broad
1945 Paladino, Joseph Salvatore, 300 Franklin Ave.
1919 Parker, John Woodcock, 84 Forest
1926 Partridge, Winthrop Prescott, 247 South Whitney
1938 Peacock, Albert Upham, 576 Farmington Ave.
1933 Phelps, Maxwell Overlock, 576 Farmington Ave.
1937 Phelps, Paul Stetson, State Tuberculosis Commission, 119 Ann
1929 Pike, Maurice Mitchell, 64 Garden
1944 Pitegoff, Gerald Irving, 242 Trumbull
1934 Priddy, Foster Eugene, 80 Farmington Ave.
1936 Quarrier, Sidney Sayre, 576 Farmington Ave.
1923 Radin, Morris Jacob, 36 Pearl
1928 Radom, Myron Michael, 242 Trumbull
1923 Rankin, Bertrand Fred, 57 Pratt
1913 Reardon, William Francis, 750 Main
1934 Reidy, D. Dillon, 750 Main
1927 Resnisky, Andrew F., 11 Asylum
1928 Reynolds, Harry St. Clair, 410 Asylum
1916 Reynolds, Harry Stephen, 18 Asylum
1930 Reynolds, Robert Gardner, 179 Allyn
1922 Roberts, Douglas James, 179 Allyn
1932 Robinson, Albert James, 55 Elm
1943 Rocco, Mario P., 1125 New Britain Ave.
1940 Roche, Arthur F., 50 Farmington Ave.
1934 Rollins, Henry Brock, 140 Garden
1909 Rooney, James Francis, 410 Asylum
1936 Rosenbaum, George Jonas, 647 New Britain Ave.
1938 Rosenthal, Ernest, 18 Asylum
1935 Roth, Frank Edward, 179 Allyn
1907 Rowley, Robert Lee, 79 Elm
1946 Rubin, Albert, 242 Trumbull
1947 Rup, Edward Carl, 525 Main
1921 Russell, G. Gardiner, 179 Allyn
1948 Russo, Joseph Nicholas, 581 Broadview Ter.
1936 Ryan, Francis James, 95 Pearl
1945 Sachs, Benjamin, 99 Main
1923 St. John, Leopold Albert, 25 Charter Oak Ave
1926 Salvin, Benjamin Lloyd, 242 Trumbull
1937 Sayers, John Joseph, 865 Park
1928 Scafarello, Peter Joseph, 410 Asylum
1932 Schaefer, Abraham Maurice, 262 Maple Ave.
1947 Schnap, Isidore, 95 Pearl
1934 Schuman, David Harold, 909 Albany Ave.
1946 Schwartz, Herbert Norman, 99 Pratt
1940 Scoville, William Beecher, 56 Garden
1932 Seibert, Alfred Frank, 700 Main
1945 Seidman, Roy Milne, 1179 Main
1942 Serbin, A. Frederick, 99 Pratt
1920 Shea, Daniel Edward, 137 North Whitney
1944 Shepard, Marguerite Dunbar, Cedarcrest
1947 Sherwood, Paul Michael, 509 Farmington Ave.
1941 Shull, John Coulter, 179 Allyn
1933 Shulman, David Nathaniel, 422 Farmington Ave.
1932 Sigal, Jacob Bernard, 99 Pratt
1940 Silver, Gershon Benjamin, 345 Garden
1936 Slossburg, David Seymour, 541 Park
1945 Smith, Charles Leonard, 179 Allyn
1944 Smith, Percy Lawson, 200 Retreat Ave.
1927 Smith, William Bowers, 80 Farmington Ave.
1944 Smith, William Leslie, 179 Allyn
1939 Smith, Wilson Fitch, 576 Farmington Ave.
1937 Sneidman, George Irving, 322 Vine
1929 Snelling, Pinckney Welch, 56 Garden
1947 Sohler, Theodore Paul, 805 Main
1946 Soifer, Irvin T., 199 Branford
1937 Spekter, Louis, 436 Capitol Ave.
1921 Spillane, Bernard, 30 Farmington Ave.
1941 Sponzo, James Joseph, 3 Webster
1927 Standish, E. Myles, 179 Allyn
1897 Standish, James Herbert, 30 Farmington Ave.
1931 Standish, Welles Adams, 30 Farmington Ave.
1905 Starr, Robert Sythoff, 179 Allyn
1946 Steege, Theodore Walter, 179 Allyn
1930 Steincrohn, Peter Joseph, 705 Asylum Ave.
1930 Stephenson, Charles Wattles, 20 South Hudson
1923 Storrs, Ralph Warren, 179 Allyn
1907 Swan, Horace Cheney, Trinity College
1914 Sweet, John Henry Throop, Jr., 179 Allyn
1932 Talbot, Henry Pierce, 165 Capitol Ave.
1930 Taylor, Andrew, 179 Allyn
1922 Thompson, Hartwell Greene, 179 Allyn
1938 Tonken, Louis Clarence, 487 Farmington Ave.
1938 Tovell, Ralph Moore, 20 South Hudson
1930 Townsend, Wilmot Charles, 301 Farmington Ave.
1947 Trifari, Leopold Mariano, 114 Woodland
1942 Truex, Edward Hamilton, Jr., 99 Pratt
1908 Tuch, Morris, 99 Pratt
1946 Tucker, Charles Albert, 56 Garden
1907 Turbert, Edward Joseph, 703 Asylum Ave.
1947 Turco, Vincent Joseph, 404 Farmington Ave.
1937 Twaddle, Paul Holmes, 576 Farmington Ave.
1937 Unsworth, Arthur Charles, 179 Allyn
1933 Uricchio, Joseph George, 260 Wethersfield Ave.
1908 Vail, George Francis, 36 Pearl
1923 VanKleeck, Euen, 700 Main
1904 VanStrander, William Harold, 945 Asylum Ave.
1926 VanWart, William Haley, 650 Main
1917 Vernlund, Carl Frithiof, 179 Allyn
1921 Vershbow, Nathan, 28 Sisson Ave.
1948 Von Salzen, Charles F., 200 Retreat Ave.
1940 Walker, Robert, 703 Asylum Ave.
1932 Wallace, Charles Kenneth, 700 Main
1932 Warring, Howard Lewis, 1756 Main
1946 Wawro, N. William, 179 Allyn
1934 Weiner, Julius Gills, 750 Main
1943 Weiner, Sylvia, 242 Trumbull
1931 Weisenfeld, Nathan, 608 Blue Hills Ave.
1936 Weissenborn, Walter, 50 Farmington Ave.
1920 Weld, Stanley Burnham, 179 Allyn
1916 Wells, Donald Breckinridge, 580 Asylum
1943 Wells, Elizabeth C., 436 Capitol Ave.
1947 Wells, John Breckenridge, 580 Asylum
1924 Whalen, Edward Joseph, 750 Main
1938 Whitcomb, Benjamin Bradford, 56 Garden
1938 White, Benjamin Vroom, 701 Asylum Ave.
1946 White, Edward Philip, 689 Asylum Ave.
1942 Whiting, Richard Charles, 700 Main
1933 Whitty, Charles Aloysius, Cedarcrest
1907 Wiedman, Otto George, 179 Allyn

948 Williams, Lloyd Parrish, 404 Farmington
946 Wills, Arthur Allison, Jr., 700 Main
943 Wilson, Archibald Cameron, 55 Elm
930 Wilson, William Augustus, 841 Asylum Ave.
941 Wineck, Morris Samuel, 179 Allyn
904 Witter, Orin Russell, 179 Allyn
933 Wood, Frank Oliver, 576 Farmington Ave.
934 Woodford, Chester North, 703 Asylum Ave.
916 Worthen, Thacher Washburn, 179 Allyn
922 Wright, William Witter, 700 Main
932 Wulp, George Adolf, 50 Farmington Ave.
912 Yergason, Robert Moseley, 50 Farmington Ave.
938 Young, William Greenhill, 200 Retreat Ave.
928 Zariphes, Constantine Argyros Paleslogos, 96 Main
947 Zarkin, Oscar Howard, 99 Pratt
934 Zeman, Burnhardt, 983 Main
946 Zeman, Michael Saxe, 179 Allyn
948 Zimmerman, Leon Ward, 179 Allyn

KENSINGTON

948 Chotkowski, Ludmil Adam, 538 Farmington Ave.

MANCHESTER

937 Barry, Joseph Charles, 156 Main
946 Besser, Edward Lambert, 11 Oak
924 Boyd, Howard, 935 Main
939 Conlon, William Linas, 33 Main
940 Diskan, Albert Elmer, 869 Main
936 Keeney, Robert Raymond, Jr., 75 Robert Rd.
925 Knapp, Robert Phineas, 146 Hartford Rd.
946 Lechausse, Ralph M., 470 Main
947 Marsh, Florence, 112 East Center
946 Massaro, Joseph, 29 Park
946 Miller, Gerard Roland, 755 Main
941 Mozzer, Alexander John, 105 Eldridge
945 Peckham, Charles Henry, 875 Main
948 Pizzi, Peter Joseph, Manchester Memorial Hospital
945 Prignano, John Vincent, 5 Middle Turnpike, West
947 Rosen, Theodore, 829 Main
941 Segal, Jacob A., 889 Main
937 Sundquist, Alfred Bernhardt, 11 Oak
946 Watson, Robert Webster, 183 East Center
936 Zaglio, Edmond Robert, 12 Myrtle

South Manchester

926 Caldwell, David Manchester, 935 Main
926 Friend, Amos Edgar, 935 Main
921 Lundberg, George Albin Ferdinand, 755 Main
930 Moriarty, Mortimer Emmett, 905 Main

NEW BRITAIN

948 Bellach, Harry, 300 Main
945 Benjamin, H. Weston, New Britain General Hospital
932 Benoit, Raoul Joseph, 51 Cedar
934 Bernstein, Dwight J., 55 West Main
930 Blogoslawski, Walter Joseph, 199 West Main
935 Bristoll, Donald Andrews, 32 Grove Hill
940 Buccheri, Francis Salvatore, 19 South High
927 Buol, Robert Stanley. 99 West Main
947 Carlson, Carl Edwin, 55 West Main
926 Chernaik, Samuel Julius, 300 Main
946 Clark, Bliss Bartlett, 32 Grove Hill
945 Clarke, Harold Metcalfe, 99 West Main
939 Daley, Louis William, 32 Grove Hill
938 Dalton, George Henry, 99 West Main
931 Darrow, John Edward, 55 West Main
928 Donnelly, Stephen Patrick, 55 West Main
941 Dorian, George David, 300 Main
941 Dorian, Edward, 300 Main
934 Dray, Edward Joseph, 259 Main
947 Dunn, Morris L., 99 West Main
942 Eisenberg, Sidney Edwin, 55 West Main
933 Ellis, Francis Duffy, Jr., 45 Cedar
936 Enander, Fred Conrad, 25 Arch
941 Goldschmidt, Myer, 25 Arch
943 Greenblatt, Harold Joseph, 99 West Main
937 Hart, Carl Jay, 259 Main
930 Kalett, Joseph, 55 West Main
942 Kraszewski, Henry Walter, 308 Main
942 Lacava, John James, 300 Main
946 Larkin, John Charles, New Britain General Hospital
946 Levine, Howard, 81 West Main
938 LoVetere, Angelo Arthur, 29 Park Pl.
930 Matteis, Joseph Theodore, 55 West Main
939 McMahon, George William, 419 Main
946 Mellion, Jacob, Walnut Hill School
934 Michalowski, Valerian Stanislaus, 300 Main
946 Mlynarski, Joseph Andrew, 43 Cedar
935 Moorad, Philip Jacob, 55 West Main
923 Mouradian, Marion Garoudy, 87 Prospect
940 Nevulis, Anthony V., 49 Lexington
938 Orbach, Egmont Julius, 81 West Main
939 Paolillo, Charles Gerald, 55 West Main
938 Parlato, Harry Anthony, 55 West Main
944 Peck, Bernard Carl, 32 Park Pl.
938 Perakos, George Peter, 300 Main
939 Pola, William Edward, 324 Elm
930 Pullen, Richard Woollard, 60 Kilbourne Ave.
936 Resnik, Edward, 272 Main
940 Rosahn, Paul Dolin, New Britain General Hospital
930 Schechtman, Charles Theodore, 81 West Main
931 Schupack, Samuel David, 99 West Main
938 Scully, Roger Tehan, 55 West Main
930 Slysz, Ladislaus Bernard, 247 West Main
928 Smith, Vincent Joseph, 55 West Main
936 Squillacote, Vincent Joseph, 55 West Main
938 Sullivan, Charles Noyes, 55 West Main
940 Tisher, Paul Winslow, 99 West Main
935 Tokarczyk, John Joseph, 32 North
941 Trapp, Francis W., 55 West Main
945 Vetrano, Samuel Anthony, 259 Main
928 Waskowitz, David, 81 West Main
934 Watson, William James, 223 West Main
932 White, John Cowles, 32 Grove Hill
941 Wilson, Dwight E., 32 Grove Hill
948 Wolfson, Samuel, New Britain General Hospital
945 Zwick, Frank, 35 South High

NEWINGTON

946 Beardsley, Lewis George, Veterans Hospital
942 Freeman, John Jay, 1247 Main
946 Friedberg, Isadore Hirsh, 1078 Main
946 Hurwitz, Alfred, Veterans Hospital
946 Kunkel, Paul, Veterans Hospital
946 O'Neil, Vincent Danforth, 26 Walsh Ave.
934 Sills, Theodore Hopkins, 897 Main
947 Yesner, Raymond, Veterans Hospital

PLAINVILLE

931 Cook, George Francis, 4 East Main
931 Frost, Lawrence Hubbard, 98 West Main
943 Iannotti, John Pasquale, 51 Whiting
934 Menousek, Joseph Albert, 104 Trumbull Ave.
938 Tortolani, Aresto Peter, 75 East Main

PLANTSVILLE

937 Connor, George Michael, 772 South Main

ROCKY HILL

1940 Kelley, Newell Raymond, 23 Riverview Rd.
1904 Moser, Oran Alexander, Elm
1947 Pierce, Harold Fisher, State Veterans Hospital
1946 Walker, Donald Albert, 253 Main

SIMSBURY

1941 Fuller, Roger Holden, Post Office Bldg.
1925 Murphy, Owen Lee, Weatogue
1939 Murphy, Thomas Denis, c/o O. L. Murphy
1932 Stretch, James Edison, Hopmeadow

SOUTHINGTON

1935 Dudac, Thomas William, 9 Center
1933 Gura, George Michael, 22 Main
1935 Nagle, William Thomas, 23 Woodruff
1929 Simmons, Eric Melville, 93 Main
1947 Stetson, Harold Prescott, 162 Main
1929 Thalberg, Reuben Edward, 32 North Main

SUFFIELD

1938 Coates, S. Paul, 328 Main
1929 Levy, William, 339 Main
1930 Upson, William Hart, 172 Main

UNIONVILLE

1932 Dawson, Lionel Montrose, 94 Perry
1937 Dunne, Edward Patrick, Main
1941 O'Connell, Enos Joseph, 60 Main

WEST HARTFORD

1913 Biram, James Harrington, 18 Birch Rd.
1947 Bowen, Frances Dorsey Thomas, 111 Somerset
1903 Brainard, C. Brewster, 10 Mountain View Dr.
1937 Burns, Maudie Marie, 30 Sulgrave Rd.
1947 Campbell, Robert Harold, 55 North Main
1942 Canby, Joseph Edward, 25 Mountain View Dr.
1931 Case, Edward Percy, 28 Brunswick Ave.
1932 Crawley, George Andrew, 330 Park Rd.
1928 Cushman, Laurence Arnold, 23 South Main
1910 Denne, Thomas Harmon, 39 North Main
1895 Elmer, Edward Oliver, 88 Ledgewood Rd.
1932 Filson, Ralph Marshall, 54 Crestwood Rd.
1926 Glazier, J. Raymond, 26 Sequin Rd.
1930 Griggs, John Bolter, 42 Middlefield Dr.
1947 Gurwitz, Jack, 139 Edgemont Ave.
1939 Hollinshead, Joseph Bentley, 1064 Farmington Ave.
1944 Klein, Rose Herchman, 58 Flagg Rd.
1920 Leak, Roy Lathen, 363 Ridgewood Rd.
1932 Lundborg, Francis Ludwig, 35 North Main
1935 Martin, John Garthwaite, 7 South Main
1943 McPartland, Charles E., Town Hall
1946 Missett, James Stephen, 62 LaSalle Rd.
1948 Morrison, Donald Richard, 1027 Farmington Ave.
1935 Murphy, Thomas Francis, 683 Asylum Ave.
1930 Parshley, Philip Ford, 818 Farmington Ave.
1943 Preston, Thomas R., 133 North Quaker Lane
1946 Purney, John, Jr., 797 Farmington Ave.
1947 Rankin, Emmett Clair, 167 Loomis Dr.
1937 Rogers, Frederick Peckham, 11 Ballard Dr.
1924 Root, Maurice Timothy, 51 North Main
1935 Root, Sophie Andrews, 51 North Main
1910 Rowley, John Carter, 205 Girard Ave.
1947 Schatten, Siegfried Sylvester, 1157 New Britain Ave.
1941 Sewall, Sidney, 351 Ridgewood Rd.
1901 Smith, E. Terry, P. O. Box 42
1935 Standish, Hilda Crosby, Greenridge Lane, Sunset Farm
1936 Stewart, Lester Quentin, 77 South Main
1941 Sullivan, Arthur Bland, 10 North Main
1939 Tennant, Robert, 156 Walden
1921 Thenebe, Carl Leonard, 720 Farmington Ave.
1937 Walton, Loftus Linwood, 797 Farmington Ave.
1942 Wells, Jean, 1018 Farmington Ave.
1922 Wentworth, John Alexander, 74 Mohawk Dr.
1931 Wienski, John Casimer, 115 Mountain Rd.
1934 Winters, John Thomas, 10 North Main

ELMWOOD

1946 Baskin, Abraham Hyman, 422 New Britain Ave.
1946 Calef, Bension, 1157 New Britain Ave.
1932 Romaniello, Rocco John, 1086 New Britain Ave.

WETHERSFIELD

1938 Carvey, Edward Vincent, 1 Garden
1933 Howard, Harold Amasa, 330 Main
1932 Storms, William Frederick, 147 Main
1940 Warren, Henry Stanley, 184 Main

WINDSOR

1942 Edson, Reginald Campbell, 24 Capen
1930 MacCready, William Harold, 38 Elm
1939 Monacella, John Manilla, 22 Elm
1947 Poirier, Theophane M., 26 Maple
1924 Pratt, Aaron Paul, 253 Broad

POQUONOCK

1947 Pomeroy, William Henry, 1852 Poquonock Ave.

WINSDOR LOCKS

1937 Coyle, Bruce James, 2 Chestnut
1948 Mullaney, Thomas Patrick, Jr., 29 North Main

OUT OF COUNTY

1947 Baptist, Vincent, 140 Main, Terryville, Conn.
1947 Berger, Alfred Jacob, Students' Health Service Un versity of Minnesota, Minneapolis, Minn.
1942 Brackin, John Tudor, Jr., U.S.V.A. Hospital, Hines, I
1911 Cobb, Albert Edward, Canaan
1947 Dolce, James A., 606 City Hall, Buffalo, N. Y.
1947 Elsberg, Charles Palmer, 460 East Main, Middletow Conn.
1946 Gallo, William Joseph, 8604 Kinsman Rd., Clevelan Ohio
1925 Gore, Michael Alvord, Box 155, Granby, Colo.
1934 Horning, Benjamin Graham, W. W. Kellogg Found tion, Battle Creek
1908 Keith, Albert Russell, 730 Washington, Annisquan Mass.
1906 Kingsbury, Isaac W. Perry, Maine
1941 Kucewicz, William Joseph, 201 West Franklin Ave Richmond, Va.
1947 Lyon, Harold P., Firestone Plantations Co., Harke Liberia, West Africa
1928 Mahoney, Daniel F. C., 729 Buena Vista, Redland Calif.
1948 Mainer, Raymond George, N. Y. Post Graduat Hospital, 303 East 20th, New York
1944 Moise, Theodore Sidney, 2101 Conustitution Ave Washington, D. C.
1939 Moxness, Bennie A., U. S. Army
1938 Mucci, Lawrence Adolf, Drs. Gamble Bros. & Arche Clinic, Greenville, Miss.
1942 O'Brien, Henry Rust, U.S.P.H.S., Washington, D. C

1944 Perkins, Joseph Augustine, McGill University, Montreal, Canada
1923 Pendleton, Ernest Raymond, Granville Rd., Westfield, Mass.
1947 Plachta, Aaron, 233 West 72nd St., New York City
1902 Purinton, Charles Oscar, New Hartford
1946 Sikes, Ralph F., Commissioner of Health, Yonkers, N. Y.
1916 Simonton, Frank Forester, 634 West Cliveden St., Philadelphia, Penn.
1944 Solomkin, Mark, Chicago Maternity Hospital, Chicago, Illinois
1937 Tait, Arthur Alfred, General Delivery, Togus, Maine
1923 Walker, William Hastings, Newtown

Litchfield County Association

President: Frank L. Polito, 24 Church St., Torrington
Vice-President: Frank D. Ursone, Greenwoods Rd., Norfolk
Secretary-Treasurer: Thomas J. Danaher, 106 Litchfield St., Torrington
Councilor: W. Bradford Walker, Cornwall
Annual Meeting, Fourth Tuesday in April
Semi-Annual Meeting, First Tuesday in October

CORNWALL

1922 Walker, Wilmarth Bradford

Cornwall Bridge

1931 Evarts, Josephine, Warren Rd.

HARWINTON

1906 Griswold, Maude Taylor

KENT

1946 Greiner, George Frederick, Kent School
1947 Grendon, David Arthur, Lane

LITCHFIELD

1946 Dautrich, Albert William, West
1935 Kilgus, John Frank, Jr., 80 West
1910 Turkington, Charles Henry, On-the-Green
1939 Warner, Charles Norton, Jr., North
1936 Wray, Edward Holloway, Jr., North

NEW HARTFORD

1942 Markwald, Heinz Wolfgang, Steele Rd.

NEW MILFORD

1939 LaTaif, C. George, 20 Bridge
1938 Stevens, Howard Granson
1947 Street, John M., 10 Aspetuck Ave.

NORFOLK

1937 Barstow, Richard Iddings, The Village Green
1934 Ursone, Frank Domenico, Greenwoods Rd.

NORTH CANAAN

Canaan

1929 Adam, Forbes Sampson
1946 Bornemann, Carl, Main
1935 Elliott, John Richard
1924 Sellew, Robert Cowan
1938 Sellew, Robert Cowan, Jr.

PLYMOUTH

Terryville

1913 Lawton, Richard John, 9 North Main
1939 Wilcox, Lloyd Mather, 19 Maple

SALISBURY

1945 Brewer, Alfred Edwin
1946 Combes, J. DeRaismes

Lakeville

1943 Mackay, William D.
1923 Peterson, Clark Kimball
1936 Wieler, Harry Julius, Hotchkiss School

SHARON

1948 Fowler, George A., Sharon Clinic
1947 Gevalt, Frederick C., Jr., Sharon Clinic
1942 Gudernatch, Gaert Steuerwald
1947 Linder, James H., Gay
1947 Noble, Robert P., Sharon Clinic

SOUTH KENT

1947 Blaine, Graham Burt, Jr., Bulls Bridge Rd.

THOMASTON

1946 Conklin, Clifford T., Jr., 16 Grand
1903 Hazen, Robert, 45 Union
1910 Kane, James Hugh, 205 South Main
1947 Samson, Daniel P., 147 Elm
1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

1946 Adams, Arthur John, Charlotte Hungerford Hospital
1937 Bienkowski, Joseph George, 24 Church
1948 Bisharat, Maurice H., 241 Main
1946 Blinkoff, Jack J., 5 Water
1946 Buckley, John Littlefield, 30 Mason
1898 Carlin, Charles Henry, 236 Main
1946 Chait, Sidney, 106 Litchfield
1930 Danaher, Thomas Joseph, 106 Litchfield
1938 Dobbs, William G. H., 24 Church
1946 Fabro, J. Alfred, 355 Prospect
1935 Garston, Louis Edward, 49 Main
1931 Giobbe, Michael Edward, 355 Prospect
1936 Goldberg, Isadore Solomon, 5 Water
1908 Hanchett, Harry Bigelow, 51 Main
1936 Hill, Emerson Stanley, 51 Main
1941 Hubert, Gilbert Richard, 19 Mason
1943 Humpage, Norbert W., 19 Mason
1947 Katzin, Benjamin, 106 Litchfield
1938 Kott, Joseph Henry, 18 Pearl
1936 LoRusso, Domenico Leonardo, 40 Main
1942 Mitchell, Gerald Vincent, 51 Main
1938 Murcko, William John, 497 Main
1923 Oelschlegel, Herbert Charles, 355 Prospect
1942 Opper, Lincoln, Charlotte Hungerford Hospital
1938 Orlowski, Andrew Williams, 19 Mason
1923 Polito, Frank Leonard, 24 Church
1942 Riendeau, Fernand Maurice, 30 Mason
1942 Riendeau, Pauline Laure, 30 Mason
1932 Samponaro, Nicholas, 241 Main
1936 Sutherland, Francis Alexander, 24 Mason
1917 Thomson, Thomas Leonard, 24 Mason
1898 Wadhams, Sanford Hosea, 908 Main
1942 Wallach, Gert M. K., 91 Church
1917 Weed, Floyd Albert, 199 Main

WASHINGTON

1927 Jackson. Arthur Hartt
1946 Simonds, John Rolf
1908 Wersebe, Frederic William

WASHINGTON DEPOT

1946 Bader, George Bernard

WATERTOWN

1946 Caney, Wilbur Hinds, 429 Main
1936 Cleary, Harold John, Main
1946 Louderbough, Henry, 313 Main
1897 Loveland, Ernest Kilborn, 48 North
1922 Martin, James Smith
1936 Meyers, Royal Abbott, 162 Main
1919 Reade, Edwin Godwin, 429 Main

WINCHESTER

WINSTED

1945 Ashley, Homer Champion, 384 Main
1938 Baker, Philip George, 26 Elm
1936 Cornelio, Francis Joseph, 153 Main
1915 English, Chester Ferrin, 64 Main
1945 Funkhouser, Selmes Paul, 26 Elm
1937 Gallo, Francis, 384 Main
1927 Herman, Donald Warner, 486 Main
1936 Levy, Aaron, 504 Main
1947 Reidy, Joseph Carey, 350 Main
1922 Sanderson, Roy Voter, 518 Main

WOODBURY

1944 Gillette, Arthur Taylor, Main

OUT OF COUNTY

1938 Atha, Henry G., 1403 Jones Blvd., Tucson, Arizona
1921 Childs, Albert Ewing, Stanfield, Oregon
1942 Downs, Elinor Fosdick, 4 The High Rd., Bronxville, New York
1917 Kennedy, William Clement, 120 Dwight, New Haven
1940 Markle, Raymond Dunsmore, 53 Cooke, Waterbury
1881 Platt, William Logan, State Hospital, Newtown

Middlesex County Association

President: PHILIP E. SCHWARTZ, 309 Main St., Portland
Vice-President: F. ERWIN TRACY, 164 Court St., Middletown
Secretary: NORMAN E. GISSLER, 164 Court St., Middletown
Councilor: HAROLD E. SPEIGHT, 70 Crescent St., Middletown

Annual Meeting, Second Thursday in April
Semi-Annual Meeting, Second Thursday in October

CENTERBROOK

1947 Crawford, George

CHESTER

1941 Callender, Eugene Frederick, Drawer F

CLINTON

1948 Kidney, James J., 20 Commerce
1937 Rindge, Norman Pember, 20 Commerce
1935 Stone, Harry Russell, 67 West Main

CROMWELL

1934 Couch, Frank Hallock, Cromwell Hall
1934 Couch, Mildred Warden, Cromwell Hall
1940 Grant, Richard Francis, 221 Main
1928 Nelson, Walter Nathaniel, 76 Main
1925 Pierson, Emily Miller, 107 Main

EAST HADDAM

1935 Horsefield, Thomas Earl, P. O. Box 40

EAST HAMPTON

1921 Felt, Paul Revere, R. F. D. No. 1
1936 Gardner, Norman Homer, 43 Main
1934 Soreff, Louis, 15 Main

ESSEX

1942 Ames, William Gard
1903 Bradeen, Frederick Barton, P. O. Box No. 221

HIGGANUM

1937 Calhoun, Hazen Albert, Jr.

MIDDLEFIELD

1947 Smith, Harold Ellsworth

MIDDLETOWN

1942 Alexander, Stanley Joseph, 516 Main
1933 Beauchemin, Joseph Adelard, Connecticut State Hospital
1941 Buckley, Willard Emrich, Middlesex Hospital
1926 Chase, Carl Clarence, 121 Main
1928 Compson, Florence Eberly Mentzer, Connecticut State Hospital
1924 Craig, George Mansfield, 119 Main
1942 Crampton, Clair Beebe, 119 Main
1933 Fekety, Stephen Henry, 675 Main
1900 Fisher, Jessie Weston, 28 Crescent
1927 Frank, Harry Selig, 144 Washington
1931 Gissler, Norman Edwin, 164 Court
1927 Grower, Julius Harry, 164 Court
1920 Harvey, Carl Clifford, 119 Main
1948 Harvey, Sanford W., 119 Main
1948 Harwood, Clarence W., 111 College
1924 Joyce, William Michael, 121 Main
1946 Knight, Harry Charles, 33 Pleasant
1928 LaBella, Louis Oronato, 612 Main
1935 Lieberman, David Leonard, Central National Bank Bldg.
1942 Lindsay, Marie Strom, Connecticut State Hospital
1925 Loffredo, Louis, 77 Crescent
1929 Magnano, Joseph, 100 Broad
1940 McLeod, Christie Ellen, 28 Crescent
1934 Minor, Lloyd Wesley, 119 Main
1896 Murphy, James, 101 Broad
1939 Palmieri, Mario Lorenzo, 54 Broad
1928 Piasta, Peter Ferdinand, 145 South Main
1946 Pilecki, Peter John, 45 Main
1943 Rafkind, Abraham Benjamin, 108 Main
1934 Roccapriore, Benjamin Anthony, 287 Washington Te
1926 Russman, Charles, Connecticut State Hospital
1945 Shenker, Benjamin Morton, 250 Main
1940 Sherwood, Henry, 516 Main
1942 Simon, Benjamin, Connecticut State Hospital
1929 Speight, Harold Edmund, 70 Crescent
1946 Sutch, Gabriel Charles, Connecticut State Hospital

1924 Sweet, Alfred Norton, 164 Court
1946 Thumim, Mark, 121 Main
1947 Toll, Nina, Connecticut State Hospital
1933 Tracy, F. Erwin, 164 Court
1919 Van Cor, Chester Arthur, 14 Walnut
1942 Vinci, Vincent John, 70 Crescent
1934 Waterman, Chester, 119 Main
1933 Whiting, Harry St. John, Connecticut State Hospital
1925 Wilder, Ella Annis, 80 South Main
1943 Wilk, Edward Kennard, Connecticut State Hospital
1922 Wrang, William Emil, 296 Main
1948 Yakovlev, Paul I., Connecticut State Hospital
1944 Yerbury, Edgar C., Connecticut State Hospital

MOODUS

1946 Berwick, Philip

OLD SAYBROOK

1941 Deming, Nelson Lloyd
1905 Granniss, Irwin, P. O. Box 312
1934 Greenberg, Aaron, Main
1946 Saunders, George Robert, P. O. Box 92

PORTLAND

1947 Epstein, Joseph I., 309 Main
1947 Longo, Americo Domenico, 344 Main
1938 Prout, Edgar Bacon, 48 Bartlett
1941 Ryan, V. Gerard, 25 Marlborough
1933 Schwartz, Philip Edward, 309 Main

SAYBROOK

Deep River

1939 Lobb, Russell Albert, 131 Main
1903 Pratt, Arthur Milton, P. O. Box 477
1932 Tate, William James, Elm

OUT OF COUNTY

1944 Bixby, Harriet, Quain & Ramstad Clinic, Bismarck, N. D.
1947 Carey, Thomas B., 1417 9th St., Douglas, Arizona
1937 Geck, Otto Francis, 95 Pearl St., Hartford
1924 Holley, Erving, Brattleboro Retreat, Brattleboro, Vermont
1944 Katzenstein, Rolf Ewald, Meriden Hospital, Meriden
1904 Kingman, James Henry, 96 Everit, New Haven
1942 Owen, Phillip Stanley, 2101 Constitution Ave., Washington, D. C.
1946 Scott, J. Clifford, Oakbourne Colony Hospital., West Chestre, Pa.

New Haven County Association

President: Samuel B. Rentsch, 61 Seymour Ave., Derby
Vice-President: James A. Gettings, 209 Whalley Ave., New Haven
Secretary: Robert H. Jordan, 64 Trumbull St., New Haven
Councilor: Courtney C. Bishop, 33 Whitney Ave., New Haven

Annual Meeting, Fourth Thursday in April
Semi-Annual Meeting, Fourth Thursday in October

ANSONIA

1916 Aaronson, Michael S., 190 Main
1937 Alu, Anthony F., 290 Main
1935 Blumenthal, Edward Jedediah, 88 Main
1938 Casagrande, John Joseph, 178 Main
1946 Galen, Jack Harris, 261 Main
1946 Haddad, Fred Melad, 156 Main
1938 Ignace, Stephen J., 126 Main
1932 Renehan, John Michael, 100 Main
1924 Senfield, Maxon Major, 110 Main
1947 Sivak, George C., 312 Main

BRANFORD

1934 Blanchard, Dana Lincoln, 87 Main
1931 Bodie, William Joseph, 256 Main
1940 Carpinella, Michael Joseph, 48 Kirkham
1917 Gaylord, Charles William, 93 South Main
1929 Levy, Nathan, 140 Montowese
1916 McQueen, Arthur Samuel, 187 Montowese
1946 Rosenthal, Richard Louis, 55 South Main

Pine Orchard

1919 Smith, George Milton

CHESHIRE

1911 Herr, Edward Albert, Main
1923 Moore, Wilbur John, Maple Ave.
1940 Neff, William Everett, Jr., Main
1939 Oxnard, Edward Warren, Maple Ave.

DERBY

1927 Burns, George Dewey, 42 Seymour Ave.
1941 D'Alessio, Charles Magno, 272 Main
1940 D'Ambruoso, Dominic Charles, 46 Atwater
1944 Davis, Donald Alan, 38 Elizabeth
1940 Dreher, Samuel Meyers, 282 Main
1943 Lencz, Erwin D., 272 Main
1944 Narowski, John Joseph, 17 Elizabeth
1910 Parlato, Michael Antonio, 270 Elizabeth
1925 Rentsch, Samuel Burton, 61 Seymour Ave.
1940 Stygar, Joseph Stanislaus, 272 Main
1947 Szanton, Victor Leo, 17 Elizabeth
1910 Treat, William Howard, 166 Minerva

EAST HAVEN

1940 Balletto, Vincent, 535 Thompson Ave.
1937 Beckwith, Donald MacFarlane, 239 Main
1940 Grenon, Ovilda Arzidas, 265 Main
1924 Taylor, Robert Mitchell, 578 Thompson Ave.

GUILFORD

1947 Lindsey, Douglas, Woodland Rd., Westlake Shores
1941 McGuire, Frank James, 29 Whitfield
1916 Smith, Frederic DeWitt, 55 Park

HAMDEN

1947 Carbone, William Charles, 1428 Dixwell Ave.
1936 Corey, Walter Van Arsdale, 1188 Whitney Ave.
1947 Elgosin, Richard B., 2440 Whitney
1943 Elkinton, Joseph Russell, 105 Clifford
1926 Ematrudo, Frederick Roys, 1756 Whitney Ave.
1944 Fischer, Alexander, 1324 Dixwell Ave.
1942 Gilmore, Helen Richter, 44 Laurel Rd.
1943 James, George R., 25 Central Ave.
1942 McKeon, James Joseph, 1828 Dixwell Ave.
1938 Parente, Leonard, 126 Church
1946 Slater, Daniel, 1100 Dixwell Ave.
1927 Slater, Morris, 1100 Dixwell Ave.

MADISON

1946 Birnbaum, Hyman Bunge
1943 Rindge, Mila Elisabeth, Boston Post Rd.
1908 Rindge, Milo Pember, Boston Post Rd.
1946 Spencer, Susan Benedict, Island Ave.

MERIDEN

1934 Affinito, Thomas, 128 West Main
1948 Beloff, Jerome Seymour, 8½ West Main
1946 Bogunlecki, Stanley Joseph, 114 East Main
1945 Brown, Marion R. Snyder, 3 Colony
1947 Brown, Patrick Neely, 73 Main
1928 Caplan, Henry, 219 West Main
1939 Caplan, Max, 197 Cooke Ave.
1937 Carey, William Clark, 61 Colony
1946 Clarke, Winthrop Irving, 43½ Colony
1937 Cohen, David Jerome, 3 Colony
1926 Conroy, Michael Joseph, 64½ East Main
1939 de La Vergne, Paul Mason, Undercliff
1927 DeRosa, Sylvester Frank, 29 Cook Ave.
1948 Dickinson, George Herbert, 119 West Main
1946 DiGiandomenico, Albert Theodore, 63 Yale
1948 Flynn, John Benedict, 118 Colony
1930 Foster, Edward Wendell, 147 West Main
1940 Fox, George Graham, 147 West Main
1921 Gibson, Cole Blease, Undercliff
1946 Giddings, James Curtis, 69 East Main
1947 Giuffrida, Francis, 118 Colony
1946 Glike, Frederick Philip, 99 Colony
1929 Hall, William Edward, 147 West Main
1946 Huss, John Henry, 118 Colony
1941 Katz, Irving, 42½ East Main
1944 Krochmal, Henry, 455 Broad
1939 L'Heureux, Jerome Arthur, 455 Broad
1934 Lirot, Stephen Leo Robert, 147 West Main
1907 Lockwood, Howard DeForest, 248 East Main
1946 Lohrmann, Walter, Undercliff
1934 Mekrut, Joseph Anthony, 68 East Main
1928 Mills, Bernard Litchfield, 94 East Main
1934 Misuk, Joseph Francis, 428 Broad
1913 Murdock, Thomas Patrick, 147 West Main
1921 Otis, Fessenden Newport, 165 West Main
1920 Otis, Israel Sabine, 165 West Main
1932 Pennington, Harry Freeman, 455 Broad
1931 Pierson, Louis A., 199 West Main
1916 Quinlan, Raymond Vincent, 5 State
1947 Robb, Samuel Aloysius, 69 East Main
1944 Ryan, Allan James, 147 West Main
1913 Smith, David Parker, 199 West Main
1942 Smith, Edward Rice, 199 West Main
1935 Solomon, Charles Isadore, 147 West Main
1943 Solomon, Rebecca Zinsher, 66 Carpenter Ave.
1934 Strickland, Harold, 128 West Main
1945 Taylor, Hoyt Chase, 199 West Main
1931 Thompson, Lawrence Everett, Undercliff
1921 Tower, Arthur Augustus, 147 West Main
1947 Vadasz, Edmond, Connecticut School for Boys
1940 Van Leuvan, James Sipple, 61 Colony
1946 White, Howard Thomas, Undercliff
1921 Wilson, James Alfred, 61 Colony

MILFORD

1938 Barney, Walter Edward, 186 Broad
1942 Davis, George Breed, 104 West River
1913 Fischer, William John Henry, 3 Lafayette
1929 Geib, Henry Albert, Zion Hill Rd.
1946 Higgins, Harold Gerard, 64 West River
1944 Langner, Helen P., 1 Shipyard Lane
1939 Lee, Frank Nelson, 56 Broad
1946 Lipkoff, Clarence Joseph, 7 River
1947 Malone, Robert Francis, 157 Gulf
1946 Marinoff, Philip A., 56 Broad
1946 Rosenthal, Benjamin B., 26 Lafayette
1948 Shea, Joseph Patrick, Jr., 15 Broadway
1941 Stetson, Charles Greaves, 114 Broad
1933 Stetson, Harry Warren, 114 Broad
1946 Timm, Alexander Berthold, Jr., 36 West Main
1940 Viola, Carl Philip, 26 Cherry
1947 Weston, Robert Alphaeus, Jr., 114 Broad

DEVON

1934 Andrus, Oliver Burton, 32 Daytona Ave.
1941 Lee, John Ranks, 21 Colonial

NAUGATUCK

1941 Bluestone, David Harrison, 9 Terrace Ave.
1923 Hill, William Edward, 150 Meadow
1940 Kennedy, Charles Stephen, 14 Hillside Ave.
1938 Reilly, Walter John, 170 Meadow
1937 Towne, Nehemiah Alvarado, 297 Church
1940 Tylec, Leo Louis, 156 Meadow
1944 Weile, Fred William, 270 Church
1926 Williams, Edward Everett, 269 Church

NEW HAVEN

1941 Aiello, Louis James, 251 Edwards
1921 Alderman, Irving Saunders, 204 Park
1925 Allen, Edward Pratt, 265 Church
1941 Allen, John Clinton, 262 Bradley
1902 Allen, Millard Filmore, 65 Dixwell Ave.
1946 Alley, Ralph David, 789 Howard Ave.
1893 Alling, Arthur Nathaniel, 190 St. Ronan
1947 Allinson, Morris Jonathan Carl, 1033 Dixwell Ave.
1932 Amatruda, Frank Gabriel, 542 Chapel
1929 Appell, Harold Seymour, 79 Trumbull
1930 Arnold, H. Bruno, 1442 Chapel
1945 Arrick, Myron S., 934 Elm
1920 Barker, Creighton, 258 Church
1908 Barrett, William Joseph, 265 Church
1896 Bartlett, Charles Joseph, 183 Bishop
1936 Bassin, Alexander Lewis, 255 Bradley
1930 Batelli, Clement Francis, 161 Church
1925 Battista, Anthony William, 111 Osborn Ave.
1947 Beauchamp, Maurice Flavian, 59 Trumbull
1909 Beck, Frederick George, 193 York
1926 Behan, Edmund Joseph, 1370 Chapel
1931 Benedict, Mary Kendrick, 291 Whitney Ave.
1940 Berlowe, Max Llewellyn, 315 Whitney Ave.
1920 Berman, Harry Loring, 1142 Chapel
1944 Berneike, Robert R., 789 Howard Ave.
1940 Biondi, Benedict, 120 Blatchley Ave.
1939 Bishop, Courtney Craig, 33 Whitney Ave.
1907 Blake, Eugene Maurice, 303 Whitney Ave.
1922 Blake, Francis Gilman, 789 Howard Ave.
1927 Blodinger, Israel Edward, 291 Whitney Ave.
1911 Boardman, Albertus Kellogg, 441 Forbes Ave.
1926 Bodie, John Allen, 221 Columbus Ave.
1939 Boisvert, Paul Leo, 789 Howard Ave.
1919 Bretzfelder, Karl Benjamin, 315 Whitney Ave.
1935 Brody, Bernard Stephen, 235 Bishop
1938 Bruckner, William J., 129 Whitney Ave.
1946 Bruno, Joseph Julius, 505 Whalley Ave.
1946 Buchan, Ronald F., 310 Cedar
1930 Bumstead, John Henry, 256 Bradley
1942 Bunting, Henry, 310 Cedar
1943 Calabresi, Massimo, 614 Orange
1934 Canfield, Norton, 789 Howard Ave.
1928 Capecelatro, Alfonso, 142 Columbus Ave.
1916 Carelli, Genesis Frank, 27 Elm
1943 Carlson, Robert Irving, 710 Woodward Ave.
1946 Castiglione, Frank Michael, 1305 State
1948 Catalan, John Ovey, 157 Franklin

1932 Celentano, Luca Eugene Humbert, 115 Howe
1943 Centrone, Patrick Anthony, 253 West Carlisle
1946 Cerrone, Luke John, 67 Chapel
1947 Cipriano, Anthony Pasquale, Grace Hospital
1946 Cheney, Charles Brooker, 789 Howard Ave.
1934 Claiborn, Louis Nixon, 303 Whitney Ave.
1937 Clark Mildred Helen, 244 Sherman Ave.
1938 Clarke, Clement Cobb, 240 Bradley
1946 Clement, David Hale, 158 Whitney Ave.
1923 Cobey, James Francis, 1210 Chapel
1922 Coffey, James Ryle, 216 Grand Ave.
1925 Cofrances, Louis William, 190 Winthrop Ave.
1904 Cohane, Timothy Francis, 400 Congress Ave.
1942 Cohen, Louis Harold, 315 Whitney Ave.
1924 Cohen, William, 1195 Chapel
1917 Collins, William Francis, 66 Trumbull
1921 Colwell, Howard Spencer, 129 Whitney Ave.
1914 Comfort, Charles Williams, Jr., 27 Elm
1931 Connolly, Arthur James, 59 Trumbull
1947 Connor, Gervase Joseph, 789 Howard
1914 Conte, Harry Albert, 38 Trumbull
1939 Conte, Mario Gero, 175 Grand Ave.
1943 Conway, David Francis, Jr., 64 Trumbull
1921 Cook, Robert Jay, 85 Whitney Ave.
1931 Corradino, Charles Louis, 516 Howard Ave.
1921 Creadick, A. Nowell, 77 Loomis Pl.
1947 Crispell, Lawrence Stearns, 789 Howard
1936 Culotta, Charles Salvatore, 291 Whitney Ave.
1946 Curnen, Edward Charles, Jr., 333 Cedar
1943 Curtis, William Boyd, 195 Church
1940 Cutler, Herman Shepard, 1308 Chapel
1924 Dallas, Marion, 248 Bradley
1943 D'Amico, Joseph, 197 James
1935 D'Amico, Michael, 291 Whitney Ave.
1934 Darrow, Daniel Cady, 789 Howard Ave.
1939 Davis, Jachin Boaz, 364 Oak
1946 Day, Harry Luther, 1076 Forest Rd.
1920 Dayton, Arthur Bliss, 129 Whitney Ave.
1942 de Forest, Gideon Knapp, 256 Bradley
1920 Deming, C. Kenneth, 257 Church
1922 Deming, Clyde Leroy, 789 Howard Ave.
1925 Dennehy, William James, 158 Whitney Ave.
1935 D'Esopo, Joseph Nicholas, 33 Whitney Ave.
1943 de Suto-Nagy, Ilona Krasso, 158 Whitney Ave.
1940 DiStasio, Frank, 251 Edwards
1943 Doff, Simon David, 1142 Chapel
1922 Duffy, William Core, 608 Whitney Ave.
1948 Dwyer, Hugh Leo, Jr., 789 Howard Ave.
1948 Ellison, Malcolm Mitchell, 789 Howard Ave.
1948 Engstrom, William Weborg, 789 Howard Ave.
1943 Epstein, Charles J., 265 Church
1923 Errico, Louis, 26 Elm
1946 Etkind, Meyer George, 1546 Chapel
1945 Evans, Joseph Harold, 1488 Chapel
1925 Evans, Theodore Schlosser, 59 Trumbull
1943 Eveleth, Malcolm Standish, 789 Howard Ave.
1935 Fenney, Philip William, 570 Elm St.
1942 Fiorito, Joseph Anthony, 59 Trumbull
1929 Fiskio, Peter William, 215 Whitney Ave.
1948 Fitzpatrick, Eugene Joseph, 243 West Elm
1945 FitzSimons, Edmund Francis, 19 Howe
1914 Flynn, Charles Thomas, 41 Trumbull
1929 Flynn, Harold Aloysius, 464 Dixwell Ave.
1946 Foord, Alan, 789 Howard Ave.
1888 Foote, Charles Jenkins, 230 Willow
1907 Ford, Alice Porter, 1400 Chapel
1929 Foster, Lewis Chandler, 256 Bradley
1924 Freedman, Barnett Philip, 322 George
1936 Freeman, David, 60 Trumbull
1940 Friedman, Irving, 121 Whitney Ave.
1937 Fry, Clements Collard, 109 College
1941 Fuldner, Russell Victor, 85 Trumbull
1946 Gardner, Horace Tillman, 333 Cedar
1940 Garofalo, Mario Louis, 1442 Chapel
1938 Geiger, Arthur Joseph, 240 Bradley
1945 Gencarelli, Alphonse Frank, 85 Trumbull
1937 Gentile, Angelo Louis, 291 Whitney Ave.
1920 Geraci, Lucian Arthur, 291 Whitney Ave.
1937 German, William John, 789 Howard Ave.
1947 Gesell, Arnold, 14 Davenport Ave.
1923 Gettings, James Augustus, 209 Whalley Ave.
1924 Giamarino, Henry James, 291 Whitney Ave.
1943 Gillson, Reginald Eric, 255 Bradley
1946 Gilmer, Roy Jones, 259 Dixwell Ave.
1947 Glaser, William, 1098 Chapel
1926 Glazer, Morris, 1204 Chapel
1941 Godfried, Milton Simons, 85 Trumbull
1947 Goetsch, John Black, 789 Howard Ave.
1910 Goldberg, Samuel James, 43 Trumbull
1941 Goldberg, Samuel James, Jr., 43 Trumbull
1912 Goldman, George, 201 Park
1927 Goldstein, Morris, 451 George
1947 Gompertz, Michael Louis, 43 Trumbull
1941 Grady, Joseph Francis, 265 Church
1941 Granoff, Morris Aaron, 419 Whalley Ave.
1948 Green, Fred Chiles, 25 Charles
1947 Green, Robert Holt, 789 Howard Ave.
1924 Greenhouse, Barnett, 107 Whitney Ave.
1948 Greenhouse, Herman Robert, 107 Whitney Ave.
1941 Grillo, Vincent James, 85 Trumbull
1927 Groark, Joseph Anthony, 145 Grand Ave.
1931 Grodin, Herman Wolmer, 840 Howard Ave.
1939 Guida, Francis Paul, 67 Trumbull
1947 Hampton, Louis J., 789 Howard Ave.
1936 Hankin, Morris Albert, 43 Trumbull
1930 Harris, Benedict Richard, 315 Whitney Ave.
1937 Harris, Jesse Samuel ,239 Bradley St.
1931 Harrison, Elizabeth Ross, 255 Bradley
1935 Hart, James Clement, 820 Elm
1920 Harvey, Samuel Clark, 789 Howard Ave.
1937 Hathaway, John Seabury, 109 College
1941 Heinemann, Martin, 107 Whitney Ave.
1916 Hendricks, Albert Ludwig, 26 Trumbull
1907 Henze, Carl William, 466 Orange
1942 Hersey, Thomas Francis, 291 Whitney Ave.
1937 Hess, Orvan Walter, 79 Trumbull
1930 Higgins, Joseph John, 48 Dwight
1948 Hillier, William Francis, Jr., 789 Howard Ave.
1922 Hillman, Maurice Manuel, 31 Howe
1916 Hirata, Isao, 1455 Chapel
1943 Hitchins, Clayton Stanley, 59 Trumbull
1943 Hodgkins, Charles Henry, 59 College
1946 Hovenanian, Michael Simon, 789 Howard Ave.
1924 Howard, Albert Joseph, 432 Whalley Ave.
1935 Howard, Marion Edith, 38 Trumbull
1915 Hynes, Frederick Henry, 195 Church
1924 Jack, John Louis, 412 Orange
1936 Jackson, Edith Banfield, 333 Cedar
1943 Jaffe, Samuel A., 235 Bishop
1948 Janzen, Arnold Herbert, 789 Howard Ave.
1927 Jenkins, Ralph Hathaway, 789 Howard Ave.
1933 Johnson, Carl Edward, 364 Oak
1938 Jordan, Robert Hough, 64 Trumbull
1946 Josephs, William Walter, 1172 Chapel
1937 Kahn, Eugen, 596 Prospect
1944 Kartin, Bernard Leon, 333 Cedar
1944 Katz, Harvey Warren, 291 Whitney Ave.
1948 Kennedy, John Joseph, Jr., 325 McKinley Ave.

1946 Kertesz, Johann, 45 Trumbull
1942 Kirby, Sam Bartholomew, 461 Humphrey
1938 Klatskin, Gerald, 107 Whitney Ave.
1928 Klebanoff, Harry Erwin, 1497 Chapel
1917 Kleiner, Simon Bretzfelder, 315 Whitney Ave.
1940 Koufman, William Bernard, 121 Whitney Ave.
1935 Krosnick, Morris Yale, 38 Trumbull
1937 Kushlan, Samuel Daniel, 303 Whitney Ave.
1948 Lach, Frank Edward, 59 Trumbull
1940 Latimer, Marvin Luther, 129 Whitney Ave.
1936 Lavietes, Paul Harold, 340 Whitney Ave.
1915 Lear, Maxwell, 1172 Chapel
1944 Lennox, Margaret Agnes, 333 Cedar
1943 Leonard, Marion, 158 Whitney Ave.
1923 Levin, Hyman Alexander, 1142 Chapel
1920 Levy, Daniel Frederick, 1288 Chapel
1905 Lewis, Dwight Milton, 128 Crescent
1948 Lewis, Herbert Daniel, 1517 Chapel
1923 Lewis, Robert Morton, 52 Trumbull
1939 Liebow, Averill Abraham, 310 Cedar
1911 Linde, Joseph Irving, 161 Church
1943 Lindskog, Gustaf Elmer, 789 Howard Ave.
1919 Little, Herman Clark, 303 Whitney Ave.
1927 Logan, William Joseph, 412 Whalley Ave.
1944 Lolli, Giorgio, 52 Hillhouse Ave.
1942 Lowman, Robert Morris, 108 Livingston
1947 Lydon, Lawrence G. M., 45 Trumbull
1926 MacCready, Paul Beattie, 442 Temple
1947 MacNish, J. Francis, 45 Trumbull
1946 Markoff, Abraham, 135 Whitney Ave.
1946 Marshak, Irving Jacob, 1142 Chapel
1927 Marshall, Carter Lee, 198 Dixwell Ave.
1928 Marvin, Harold Myers, 303 Whitney Ave.
1921 Massa, Anthony Francis, 19 Howe
1931 Mastroianni, Luigi, 248 Bradley
1938 Mathews, Frank Pelletreau, 109 College
1925 Maurer, Lloyd Leslie, 41 Trumbull
1934 McAlenney, Paul Francis, Jr., 250 Edwards
1913 McGuire, William Charles, 5 Elm
1947 Meigs, J. Wister, 310 Cedar
1940 Mendelsohn, William, 442 Temple
1916 Mendillo, Anthony Joseph, 45 Trumbull
1933 Mendillo, John Carleton Francis, 255 Bradley
1948 Michael, Stanley Theodore, 333 Cedar
1938 Mignone, Joseph, 291 Whitney Ave.
1947 Milici, John Joseph, 1342 Chapel
1942 Millen, Samuel Robert, 545 Dixwell Ave.
1942 Mogil, Marvin, 59 College
1930 Mongillo, Frank, 5 Elm
1946 Moore, Burness Evans, 333 Cedar
1942 Moore, Donald Bernard, 588 Howard Ave.
1945 Morgan, Kenneth Remsen, 168 Prospect
1916 Morse, Arthur Henry, 364 Oak
1946 Moss, Harry George, 646 Dixwell Ave.
1943 Mott, Frederick Edward, 38 Trumbull
1922 Musselman, Luther Kyner, 107 Whitney Ave.
1944 Mylon, Ernst, 358 Central Ave.
1921 Nahum, Louis Herman, 1142 Chapel
1940 Nesbit, Robert Raymond, 1442 Chapel
1946 Newman, Harry Rudolph, 1172 Chapel
1922 Newman, Joseph Thomas, 150 Shelton Ave.
1935 Newman, Richard, 158 Whitney Ave.
1914 Nichols, Ralph Wilbur, 57 Trumbull
1932 Nodelman, Jacob, 26 Elm
1947 O'Brasky, George Harry, 1142 Chapel
1933 O'Brasky, Louis, 1172 Chapel
1920 O'Brien, William Henry Joseph, 265 Church
1922 O'Connor, Denis Stanislaus, 241 Edwards
1931 Oughterson, Ashley Webster, 38 Trumbull
1936 Palmieri, Michael Walter, 551 Howard Ave.
1946 Parrella, Gioacchino Sisto, 587 Howard Ave.
1946 Pasternak, Maxwell, 129 Whitney Ave.
1929 Paul, John Rodman, 789 Howard Ave.
1943 Pelliccia, Orlando, Jr., 525 Whitney Ave.
1940 Perham, William Sidney, 129 Whitney
1922 Perrins, Harlan Bassett, 59 Trumbull
1925 Peters, John Punnett, 789 Howard Ave.
1927 Petrelli, Joseph, 455 Orange
1946 Petrillo, Charles, 67 Trumbull
1923 Philipson, Samuel, 100 Whitney Ave.
1909 Phillips, Frank Lyman, 303 Whitney Ave.
1935 Piazza, George Joseph, 78 Orchard
1942 Piccolo, Pasquale A., 41 Trumbull
1931 Pinn, Abraham Samuel, 75 Sherman Ave.
1942 Pitegoff, Charles Haskell, 1442 Chapel
1927 Poole, Allan King, 107 Whitney Ave.
1938 Poverman, David, 67 Trumbull
1927 Powell, Wilson, 1266 Forest Rd.
1925 Powers, Grover Francis, 789 Howard Ave.
1934 Rademacher, Everett Stanley, 442 Temple
1903 Rand, Richard Foster, 246 Church
1943 Redlich, Frederick Carl, 333 Cedar
1941 Riccio, Joseph Salvatore, 1059 Dixwell Ave.
1924 Riccitelli, Mariano Louis, 476 Howard Ave.
1946 Richards, William Raymond, 364 Oak
1947 Riesman, John Penrose, 789 Howard Ave.
1938 Rilance, Arnold Boon, 442 Temple
1929 Roberts, Frederick William, 158 Whitney Ave.
1920 Rogers, Orville Forrest, 109 College
1929 Rogowski, Bernhard Albert, 75 Whitney Ave.
1941 Roth, Oscar, 42 Trumbull
1932 Rothschild, Morris Loeb, 315 Whitney Ave.
1941 Rozen, Alan Abraham, 113 Howe
1937 Rubin, George Alan. 1150 Chapel
1914 Russell, Thomas Hubbard, 57 Trumbull
1922 Russell, Walter Irving, 139 Alston Ave.
1920 Russo, Joseph Daniel, 255 Edwards
1921 Ryder, William Harold, 250 Edwards
1933 Salinger, Robert, 256 Bradley
1944 Salter, William Thomas, 333 Cedar
1911 Scarbrough, Marvin McRae, 47 Trumbull
1931 Scholl, Robert Frederick, 215 Whitney Ave.
1924 Scott, Clifton Russell, 215 Whitney Ave.
1920 Seabury, Robert Brewster, 315 Whitney Ave.
1916 Segnalla, Ernest, 613 Chapel
1923 Serafin, Peter James, 809 State
1928 Shay, Francis Leo, 354 Alden Ave.
1923 Shea, Michael Stephen, 500 Howard Ave.
1915 Sheahan, William Lawrence, 59 College
1929 Shure, Abraham Lewis, 1184 Chapel
1947 Sigel, Harry, 85 Trumbull
1923 Silverberg, Samuel Joshua, 315 Whitney Ave.
1913 Skiff, Stuart Ernest, 1194 Chapel
1944 Smirnow, Max Ruskin, 1142 Chapel
1923 Smith, Charles Seaver, 59 College
1942 Smith, Frederick Francis, 84 Dixwell Ave.
1947 Smith, James Thomas, 789 Howard Ave.
1914 Smith, Marvin, 356 Humphrey
1940 Smith, Norman Nathaniel, 291 Whitney Ave.
1946 Snoke, Albert Waldo, 789 Howard Ave.
1927 Snurkowski, Charles Vincent, 487 Orange
1927 Sperandeo, Anthony, 441 Orange
1896 Sperry, Frederick Noyes, 107 Whitney Ave.
1942 Spiegel, Charles Markle, 59 College
1939 Spinner, Samuel, 85 Trumbull
1907 Standish, Frank Billings, 193 York
1946 Stilson, Carter, 158 Whitney Ave.
1925 Stone, Emerson Law, 129 Whitney Ave.

1948 Stowe, Lyman Maynard, 789 Howard Ave.
1920 Strauss, Maurice Jacob, 41 Trumbull
1947 Sulkowitch, Hirsch, 75 Whitney Ave.
1897 Sullivan, John Francis, 1346 Chapel
1923 Sullivan, Thomas Joseph, 495 Orange
1946 Swirsky, Morgan Yale, 1204 Chapel
1946 Taffel, Max, 789 Howard Ave.
1947 Thompson, Walter Andrew Lewis, 241 Edwards
1915 Thoms, Herbert, 789 Howard Ave.
1940 Thorne, Lewis, 109 College
1911 Tileston, Wilder, 442 Temple
1947 Tortora, Frank, 386 Ferry
1923 Tyler, Margaret, 158 Whitney Ave.
1942 Vegliante, Michael E., 174 Bradley
1896 Verdi, William Francis, 27 Elm
1943 Verstandig, Charles Coleman, 129 Whitney Ave.
1924 Vestal, Paul William, 79 Trumbull
1941 Vollero, Andrew, 469 Howard Ave.
1926 Wakeman, Edward Taylor, 240 Bradley
1945 Waldemar-Kertész, Johanna, 201 Park
1919 Weil, Arthur, 291 Whitney Ave.
1942 Weir, Margaret Lathrop Bronson, 200 Edgehill Rd.
1902 Welch, Harry Little, Hotel Taft
1907 Wheatley, Louis Frederick, 61 Trumbull
1947 White, Robert Morris, 59 Trumbull
1916 Whiting, Leonard Clark, 121 Whitney Ave.
1936 Wies, Frederick Albert, 255 Bradley
1941 Wilkinson, Arthur Gilbert, 59 Trumbull
1947 Willard, William Robert, 310 Cedar
1931 Willner, Otto, 61 Trumbull
1947 Wilson, Charles Christopher, 310 Cedar
1935 Wilson, Hugh Monroe, 789 Howard Ave.
1931 Wilson, William Rives, 255 Bradley
1947 Winer, Paul, 204 Park
1921 Winternitz, Milton Charles, 310 Cedar
1922 Winters, Sidney, 1175 Chapel
1895 Wurtenberg, William Charles, 445 St. Ronan
1924 Yavis, John Constantine, 115 Dwight
1920 Yudkin, Arthur Meyer, 257 Church
1942 Zaff, Fred, 135 Whitney Ave.
1947 Zagraniski, Raymond Joseph, 977 Whalley Ave.

NORTH HAVEN

1941 Cashman, Justin Laurence, Broadway
1943 Gillis, Grace Elaine, St. John
1947 James, Mary Latimer, Hartford Turnpike
1913 Lang, William Peter, The Cedars
1940 Parrella, Louis Arnold, Broadway
1923 Taylor, Sterling Price, Broadway and Post Rd.

SEYMOUR

1938 Chobian, Joseph Aloysius, 195 Main
1941 Harvey, Edward Regis, 119 Main
1946 Harvey, Edward Regis, Jr., 119 Main
1934 Rogol, Oscar, 135 Main

SOUTHBURY

1942 Deutsch, Joyce Victoria, Southbury Training School
1935 Yannet, Herman, Southbury Training School

WALLINGFORD

1943 Boyarsky, Harry Morton, 450 Center
1947 Boyd, Robert Booth, 176 North Main
1932 Breck, Charles Arthur, 176 North Main
1929 Campbell, Sherburne, 270 Center
1930 Carrozella, John Christy, 50 South Main
1941 Dayton, Theodore Read, Gaylord Farm
1942 Ferguson, James Fulton, Jr., 176 North Main
1942 Gushee, Edward Stockbridge, 187 North Main
1946 Konopka, Frank Joseph, 235 Center
1905 Lyman, David Russell, Gaylord Farm
1911 McGaughey, James David, 261 Center
1947 McGaughey, James David, III, 261 Center
1916 Morriss, W. Haviland, Gaylord Farm
1942 Murphy, Thomas Basil, 324 North Elm
1940 Pelz, Kurt, 26 South Main
1919 Sheehan, Mark Thomas, 245 Center
1931 Spignesi, John Theodore, 37 North Main

WATERBURY

1924 Allen, Harry Everett, 30 Prospect
1929 Atkins, Samuel Maurice, 63 Central Ave.
1923 Audet, Charles Henry, 42 Church
1942 Backhus, Louis Charles, 79 Greenleaf Ave.
1910 Barber, Walter Lewis, Jr., 87 North Main
1937 Berman, Bernard Alfred, 65 Bank
1908 Bevans, Theodore Frank, 111 West Main
1931 Bizzozero, Orpheus Joseph, 59 Cooke
1942 Blau, Rudolf, 47 Cooke
1946 Bloomberg, Maxwell H., 53 Cooke
1939 Bonner, Robert Alexander, 51 West Main
1943 Bonner, Robert Alexander, Jr., 43 Central Ave.
1910 Brennan, Patrick Joseph, 135 West Main
1928 Brown, Abe Solomon, 58 Central Ave.
1940 Burke, Joseph Francis, 39 Central Ave.
1948 Cappelletti, A. Joseph, Waterbury Hospital
1945 Carpentieri, Anthony Louis, 18 Aetna
1941 Cole, Clarence Hummer, 111 West Main
1935 Collins, Joseph Osborn, 64 Robbins
1942 Coppeto, C. James, 220 East Main
1932 Corbett, Herbert John, 14 Central Ave.
1942 Coshak, Morris, 58 Holmes Ave.
1928 Cottiero, Thomas, 21 Cooke
1947 Cox, Marcus Edward, St. Mary's Hospital
1928 Curran, Harold Joseph, 111 West Main
1940 Damiani, Rudolph Andrea, 5 Cooke
1942 DeCristoforo, Ralph, 291 North Main
1948 Devenis, Michael M., 20 East Main
1912 Dillon, John Henry, 325 East Main
1948 DiLorenzo, Salvatore F., 195 Grove
1941 Dionne, Ulric Albany, 64 Holmes Ave.
1927 Dreher, Alfred Charles, 171 North Main
1941 DuBois, Robert Lionel, 29 Central Ave.
1947 Dwyer, Christopher Edward, 18 Pine
1902 Dwyer, Patrick James, 95 North Main
1927 Edlin, Charles, 24 Central Ave.
1922 Fabricant, Samuel Elmer, 9 Cooke
1937 Finkelstein, William, 103 North Main
1926 Finn, Alfred Joseph, 164 West Main
1926 Fitzpatrick, Edward Earl, 111 West Main
1927 Foster, John Hess, 77 North Main
1928 Freiheit, John Martin, 85 Grove
1909 Gancher, Jacob, 275 North Main
1948 Gancher, Ralph, 275 North Main
1923 Godfrey, Edward John, 235 Grand
1914 Good, William Murray, 63 Center
1915 Green, Jacques Henry, 171 North Main
1947 Grillo, William, 56 Franklin
1947 Gualtieri, Michael Vincent, 27 Cooke
1947 Hanson, Millard Charles, 95 North Main
1942 Harty, John E., 101 North Main
1933 Harvey, Joseph LeRoy, 222 Ledgeside Ave.
1930 Herrmann, Albert Edward, 111 West Main

1931 Hetzel, Joseph Linn, 51 Central Ave.
1939 Hinchey, Richard James, 43 Central Ave.
1919 Jackson, Andrew Joseph, 111 West Main
1942 Jennes, Milton Leo, 76 Center
1939 Jennes, Sidney Weinberg, 135 West Main
1922 Johnson, Arthur August, 59 Central Ave.
1915 Johnston, Ernest Hillock, 18 Saving
1944 Karlin, Frank Lewis, 95 North Main
1946 Kelly, LeMoyne Copeland, 95 North Main
1914 Kirschbaum, Edward Harry, 20 Grove
1944 Koleshko, Lawrence Jacob, 24 Central Ave.
1940 LaBrecque, Frederick Charles, 77 Central Ave.
1922 Larkin, Charles Lewis, 101 North Main
1945 Lenkowski, William John, 207 South Elm
1941 Lewicki, Edward Stanley, 36 North Main
1924 Lombardi, Pasquale Frederick, 46 Prospect
1948 Lovelace, Theodore Ronceverte, 494 North Main
1946 Mangeniello, Louis Ottone Joseph, 29 Lexington Ave.
1939 Margolius, Norman Calvin, 50 Holmes Ave.
1941 Mayo, Elliott Russell, 129 Prospect
1916 McGrath, John Henry, 309 East Main
1943 Meo, Richard Carl, 80 Central Ave.
1941 Merriman, Henry, 115 Prospect
1925 Merriman, Merritt Heminway, 115 Prospect
1947 Monagan, Thomas M., 195 Grove
1928 Morrill, Harold Frost, 300 West Main
1932 Mullen, John Joseph, 135 West Main
1947 Mulligan, Thomas Michael, 19 Holmes Ave.
1929 Neuswanger, Chris Harold, 89 North Main
1948 Ohman, Richard John, 707 Watertown Ave.
1948 Olore, Louis, 195 Grove
1942 Pasetto, Edo, 63 Central Ave.
1923 Platt, Irving Smith, 30 Prospect
1943 Pollard, Robert Lonsdale, 24 Central Ave.
1901 Pomeroy, Nelson Asa, 96 Hillside Ave.
1940 Post, Edward Andrew, 111 West Main
1931 Pyle, Edwin, 95 North Main
1916 Quinn, Raymond James, 730 Baldwin
1941 Reichenbach, Alfred Edelbert, 171 North Main
1939 Reynolds, Joseph Alban, 135 West Main
1920 Root, James Harold, 103 North Main
1947 Root, James Harold, Jr., 103 North Main
1946 Rosenberg, Harold Arthur, 29 Central Ave.
1925 Ruby, Max Harold, 47 Prospect
1939 Ruby, Robert James, 47 Prospect
1914 Ryder, Raymond Harrison, 52 Central Ave.
1941 Saltzman, Jacob A., 135 West Main
1931 Sandulli, Gaetano Renato, 64 Cooke
1928 Santoro, Grace Marie, 95 North Main
1933 Shea, Vincent Timothy, 20 East Main
1948 Shearer, John Kennedy, 89 North Main
1941 Sklaver, Joseph, 95 North Main
1935 Slavin, Joseph E., 79 North Main
1906 Smith, Egbert Livingston, 292 West Main
1946 Smith, Jasper Archer, 77 Central Ave.
1931 Staneslow, John Stanislovaitis, 21 Holmes Ave.
1924 Stettbacher, Henry John, 28 Prospect
1946 Sullivan, Arthur Francis, 111 West Main
1906 Swenson, Andrew Clay, 43 Central Ave.
1947 Teiger, Paul, 58 Holmes Ave.
1947 Tynan, James G., 164 West Main
1916 Vastola, Anthony Patrick, 103 North Main
1920 Webber, Edwin Russell, 95 North Main
1944 Wertheimer, John, 195 North Main
1946 Whalley, Evan Joseph, 720 Baldwin
1942 Wilcox, Frederick C., Jr., 64 Robbins
1943 Zerkowitz, Frederick, 79 North Main
1942 Zonn, Seymour Israel, 34 Holmes Ave.

WEST HAVEN

1938 Chasnoff, John Arthur, 328 Main
1943 Cozzolino, Eugene Norris, 640 Savin Ave.
1923 Giannotti, Carl Charles, 399 Savin Ave.
1943 Kessler, Frederick, 233 Elm
1940 Koster, Leo William, 381 Main
1930 Milano, Nicolas Antonio, 271 Elm
1923 O'Connell, William Michael, 295 Main
1915 Rogers, Platt Harrison, 228 Elm
1945 Saposnik, Jacob Jay, 610 Campbell Ave.
1933 Snavely, Marion Elizabeth, 546 Washington Ave.

WOODBRIDGE

1908 Arnold, Harold Sears

OUT OF COUNTY

1937 Abrashkin, Mortimer Dick, Veterans Administrati Hospital, Coral Gables, 34, Fla.
1945 Albom, Jack Jonathan, Kings County Hospit Brooklyn, N. Y.
1946 Banay, Ralph Steven, 709 Park Ave., New York C
1946 Barald, Fred Charles, Veterans Hospital, Jeffers Barracks, Mo.
1927 Blumer, George, 573 Los Arboles Lane, San Mari Calif.
1943 Bowen, Joseph John, Jr., 4211 Oakford Ave., Bal more, Md.
1932 Budau, John Harry Diederichs, P. O. Box 148, Roc ledge, Florida
1924 Carroll, William Edward, 184 North Walnut, E Orange, N. J.
1935 Climo, Samuel, Veterans Administration Hospit 132 West Kingsbridge Rd., Bronx, N. Y.
1946 Cressy, Norman Leo, Veterans Hospital, Newingt
1922 Duffy, Vincent P., 218 McGraw Ave., Grafton, W Virginia
1921 Dunham, Ethel Collins, 1815 45th, N. W., Washingt D. C.
1943 Durlacher, Stanley Henry, Emmorton Rd., Bel A Md.
1916 Egan, John Joseph, Vets. Admin., Newington
1937 Eliot, Martha May, 1815 45th, N.W., Washington, D.
1948 Finner, Richard Webster, Connecticut State Hospit Middletown, Conn.
1947 Frazer, John P., 1133 Punchbowl, Honolulu, Hawa
1946 Friesen, Arnold, Friends Hospital, Frankford, Phil delphia, Penn.
1923 Garcia, Alphonse G., Prospect, Moosup
1939 Gendel, Benjamin Robert, Kennedy Veterans Hospit Memphis, Tenn.
1941 Gerstl, Bruno, Veterans Hospital, Oakland, Calif.
1946 Glorig, Aram, Jr., Walter Reed General Hospit Washington, D. C.
1943 Harvey, Thomas Stoltz, Philadelphia General Hospit Philadelphia, Penn.
1943 Herrick, Francis Leach, Putnam Memorial Hospit Bennington, Vt.
1943 Hieronymus, Ethel Emelia, 1304 Everett Ave., Loui ville, Ky.
1943 Hoff, Ebbe Curtis, Medical College of Virginia, Rich mond, Va.
1946 Howard, Weaver Oscar, Veterans Hospital, Tuskege Alabama
1929 Hughson, Donald Thomas, 208 East Wisconsin Av Milwaukee, Wis.
1942 Hughson, Frances Gramling, 208 East Wisconsin Av Milwaukee, Wis.

27 Johnson, Harold Albert, R. F. D. No. 2, Watertown
46 Keating, George A., 2810 Avenue L, Brooklyn, N. Y.
36 Klumpp, Theodore George, 170 Varick St., New York N. Y.
42 Krosnick, Gerald, 818 Harrison Ave., Boston, Mass.
42 Laube, Paul Julius, Cheeloo University, Tsinan-Shantung, China
35 Leddy, Percy Allen, R. F. D. No. 6, Portland, Maine
07 Leonard, George Arthur, 5902 Prytania St., New Orleans, La.
43 Lutz, Walter G., Yale Club, New York, N. Y.
47 MacQuigg, David Ellison, William Beaumont Hospital, El Paso, Texas
44 McCabe, Edward James, 2 East 55th, New York, N. Y.
06 McLarney, Thomas Joseph, 67 Catherine St., Hartford
17 Merrill, William Truman, 67 Fullers Lane, Milton, Mass.
94 Peck, Robert Ellsworth, R. F. D. No. 2, Concord, New Hampshire
47 Rogawski, Alexander Simon, 8827 Olympic Blvd., Beverly Hills, Calif.
45 Sachs, Kurt, Veterans Administration Hosptial, Muskogee, Okla.
40 Sadusk, Joseph Francis, Jr., Room 3C-558, Pentagon Building, Washington 25, D. C.
10 Sanford, Charles Edwin, 1410C. 125th, Seattle, Wash.
46 Saunders, Allen Irving, 54 Elm Hill Ave., Roxbury, Mass.
39 Sayers, Daniel O'Connell, Winter General Hosptial, Topeka, Kansas
46 Shaffer, Irvin G., Community General Hospital, Reading, Penn.
46 Shumacker, Harris B., 1040 West Michigan, Indianapolis, Indiana
46 Stein, Julius Daniel, Lincoln Hospital, Bronx N. Y.
36 Stevens, Marvin Allen, 71 Park Ave., New York, N.Y.
46 Swift, William Everett, Jr., Hepatitis Research Center, 120 Station Hospital, A. P. O. 696-6, c/o P. M., New York.
41 Sword, Brian Collins, 630 North Broadway, Yonkers, N. Y.
42 Tarbell, Luther Allen, Veterans Administration, Batavia, N. Y.
36 Van Antwerp, Lee Douglas, Box 5110, Chicago, Ill.
45 Wagner, Herbert Theodore, Jr., Chicago, Ill.
46 Weed, Chester Albert, Manhattan Eye, Ear, Nose and Throat Hospital, 210 East 64th, New York Ctiy
42 Wentworth, John Hall, Norburn Hospital, Asheville, N. C.
33 Wilson, George Campbell, 92 Varick Rd., Waban, Mass.
42 Woodruff, Lorande Mitchell, 86 Clifton St., Belmont, Mass.
33 Zimmerman, Harry Martin, Montefiore Hospital, New York City

New London County Association

esident: Henry A. Archambault, 2 North Second Ave., Taftville
ice-President: C. John Satti, 131 Montauk Ave., New London
cretary-Treasurer: Thomas Soltz, 52 Huntington St., New London
ouncilor: George H. Gildersleeve, 310 Main St., Norwich

Annual Meeting, First Thursday in April
Semi-Annual Meeting, First Thursday in October

COLCHESTER

1935 Friedman, Irving, 16 Norwich Ave.
1921 Pendleton, Cyrus Edmund, 13 Main
1942 Schwarz, H. Peter, 11 Main

EAST LYME

Niantic

1941 Dart, Frederick Bond, 61 Main
1948 Duennebier, Harold W., Lincoln
1934 MacLeod, Edith Alice, State Farm for Women

GRISWOLD

Jewett City

1916 McLaughlin, John Henry, 37 Main
1934 O'Neil, Martin Leo, 8 Park Sq.
1948 Sawyer, James D., 110 Main

GROTON

1916 Barnum, Charles Gardner, 230 Thames
1918 Douglass, Edmund Latham, 188 Thames
1943 Goldmeier, Erich, 274 Thames
1934 Hewes, Carlisle Tyson, 242 Thames
1941 Kaschub, Robert W., Electric Boat Co.
1946 MacDougall, Archibald Duncan, 242 Thames
1944 Sutton, Paul, 280 Mitchell
1942 Szlemko, Emil Alex, 27 Poquonnock Rd.

LYME

1927 Ely, Julian Griffin, R. F. D. No. 2

MONTVILLE

Uncasville

1944 Donohue, John Daniel
1936 Lubchansky, Jacob Harris
1929 Rasmussen, Hans Norman

NEW LONDON

1933 Becker, Joseph, 302 State
1928 Blank, Eric Henry, 240 Williams
1933 Brosnan, John Francis, 302 State
1916 Cheney, George Philip, 179 Montauk Ave.
1936 Comstock, Edward Richard, 108 State
1938 DeAngelis, Louis, 260 Broad
1909 Dunn, Frank Martin, 26 Broad
1931 Dyer, Charles Edward, 102 Montauk Ave.
1947 Fagan, Frederick J., Lawrence Memorial Hospital
1936 Ferguson, Helen Knox, 508 Montauk Ave.
1906 Ganey, Joseph Matthew, 205 Williams
1934 Gipstein, Edward, 181 Broad
1947 Grayson, Merrill, 183 Williams
1947 Haines, Henry Lippincott, 309 State
1939 Hartman, Frederick Bittinger, 58 Huntington
1922 Hendel, Isidor, 50 State
1934 Henkle, Robert Theodore, 51 Federal
1895 Heyer, Harold Hankinson, 70 Coit
1936 Irwin, Harold Hyman, 158 Williams
1947 Karpel, Saul, 116 Federal
1921 Kaufman, Charles, 308 State
1940 Krinsky, Charles Morris, 302 State
1924 Labensky, Alfred. 85 Federal
1921 Lena, Hugh Francis, 154 Broad
1931 Loiacono, Anthony Joseph, 262 Broad
1947 Loiacono, Richard A., 260 Broad
1934 Morse, Willard Jackson, 32 Channing
1921 Murray, Thomas J., 34 Huntington

1946 Nielsen, Tage M., 195 Williams
1936 Rapp, Albert Grant, 325 State
1929 Satti, C. John, 131 Montauk Ave.
1938 Smilgin, Victor Edward, 265 Williams
1921 Soltz, Thomas, 52 Huntington
1929 Starr, Richard Mallory, 45 Huntington
1942 Sturtevant, James Melvin, 58 Huntington
1904 Sullivan, Daniel, 833 Ocean Ave.
1940 Sulman, Morris, 203 Montauk Ave.
1899 Taylor, John Clifton, 159 State
1933 Taylor, Robert Nelson, 159 State
1947 Verie, Kathryn E., 159 Ocean Ave.
1936 Ward, Lawrence Shapiro, 325 State
1925 Warren, Hill Freeman, 100 State
1922 Wellington, Harold Wentworth, 309 State
1935 Wies, Carl Hendricks, 58 Huntington
1913 Wilson, Frank Emery, 302 State
1938 Woodward, Joseph Cutler, 116 Federal St.
1947 Wool, Joseph M., 183 Williams

NORWICH

1910 Agnew, Robert Robertson, 257 Main
1947 Agrin, Alfred, Norwich State Hospital
1946 Albamonti, Mario John, 257 Main
1935 Bergendahl, Harold Andrew, 63 Broadway
1942 Bielecki, Casimer Eugene, 35 Main
1908 Brophy, Edward Joseph, 372 Washington
1945 Bryan, Kathryn May, 2 Franklin
1916 Callahan, John William, 308 Main
1915 Campbell, Hugh Baird, 111 Broad
1947 Colett, Ilse Vivien, Norwich State Hospital
1943 Daly, Joseph Lawrence, Jr., Norwich State Hospital
1946 Danburg, Dwight Sterling, Uncas-on-Thames
1925 Dixon, Henry Campbell, 16 Franklin
1897 Donohue, James Joseph, 43 Broadway
1916 Driscoll, William Thomas, 257 Main
1942 Drobnes, Sidney, 71 Main
1942 Ferrara, Michael, Uncas-on-Thames
1916 Freeman, Albert Clark, 54 Broadway
1927 Gildersleeve, George Harold, 310 Main
1948 Guss, Louis, 71 Main
1945 Guthrie, Riley Henry, Norwich State Hospital
1935 Hale, Virginia Anne, Norwich State Hospital
1947 Hanaghan, James Albert, Uncas-On-Thames
1935 Higgins, Harold William, 40 Shetucket
1946 Kelley, Winfield Orthello, Uncas-on-Thames
1938 Kettle, Ronald Harry, Norwich State Hospital
1947 LaPierre, Arnaud R., 187 Main
1936 Mahoney, Joseph John, 99 Main
1922 Manwaring, Ier Jay, East Great Plains
1922 Markoff, Kopland Karl, 16 Franklin
1947 Martin, John Edward, 45 Main
1937 Moore, Maurice R., 88 Central Ave.
1935 O'Connell, Patrick Henry, 10 Shetucket
1942 Oppenheimer, Kurt, 257 Main
1936 Osgood, Charles, 257 Main
1942 Pepe, Anthony James, Norwich State Hospital
1947 Peterson, Eloise B., Drawer 508, Norwich
1947 Phillips, Nicholas T., 10 Shetucket
1934 Quintiliani, Albert, 43 Broadway
1932 Rabinovitch, Alec, 96 McKinley Ave.
1930 Raymer, John George, 59 McKinley Ave.
1935 Sears, Lewis, 257 Main
1938 Segel, Solam, 257 Main
1944 Smith, Bryce A., Uncas-on-Thames
1929 Suplicki, John William, 257 Main
1921 Sussler, David, 65 Main
1925 Thompson, Clarence George, 257 Main
1931 Urquhart, Robert Glen, 91 Main
1935 Weidman, William Harold, R. F. D. No. 8, Scotla Rd.
1932 Wener, William Victor, 241 Main

Taftville

1933 Archambault, Henry Allard, 2 North Second Ave.

OLD LYME

1909 Devitt, Ellis King
1947 Von Glahn, Harold Diedrich, Ferry Rd.

STONINGTON

1934 Haliday, Earle George, 168 Water
1934 Veal, William Thomas, 99 Water

Mystic

1947 Crandall, Bradford Blanchard, 31 Gravel
1941 Fowler, Roger Nathaniel, 5 Library
1928 Hill, Edward Roland, 43 East Main
1947 Platt, John Wadsworth, 8 Elm
1941 Ryley, Roger Noyes, 35 Willow

WATERFORD

1946 Coppola, Edward Attilio, 2 Highland Dr.
1935 Lukoski, Walter Anthony Francis, The Seaside
1913 O'Brien, John Francis, The Seaside
1942 Tombari, S. Paul, The Seaside

OUT OF COUNTY

1946 Gould, Louis N., 114 St. Clair Rd., Hamilton, Oh
1932 Griswold, Matthew, 109 College, New Haven
1947 Katz, Morris E., Beth Israel Hospital, Boston, Mass.
1946 Mezey, Cornelius M., Columbus Hospital, Great Fall Montana
1940 Sabloff, Jack, 165 Capitol Ave., Hartford
1912 Williams, Charles Mallory, 38 West, Nassau, B. W.

Tolland County Association

President: John P. Hanley, 15 Church St., Stafford Spring
Vice-President: Ralph B. Thayer, Main St., Somers
Secretary: Francis H. Burke, 45 Park St., Rockville
Councilor: Charles T. LaMoure, Windham Center

Annual Meeting, Third Tuesday in April
Semi-Annual Meeting, Third Tuesday in October

COVENTRY

South Coventry

1891 Higgins, William Lincoln

ELLINGTON

1940 Levine, Leonard Warren

SOMERS

1946 Schillander, Carl Axel, Box 100
1921 Thayer, Ralph Bruce, Main

STAFFORD

Stafford Springs

1908 Hanley, John Patrick, 15 Church
1941 Luckner, Wendelin George
1935 Schiavetti, Alfred, 11 Church

VERNON

Rockville

933 Burke, Francis Henry, 45 Park
908 Dickinson, Francis McLean, 38 Elm
923 Ferguson, Roy Cameron, 57 Union
918 Flaherty, John Edward, 42 Elm
921 Metcalf, Elliott Harrison, 50 Elm
897 O'Loughlin, Thomas Francis, 26 North Park
931 Schneider, William, 34 Union
946 Squillante, Orlando John, 28 Elm

OUT OF COUNTY

918 LaMoure, Charles TenEyck, Windham Center
940 Leonard, Robert John, Hospital of St. Raphael, New Haven

Windham County Association

resident: Reuben Rothblatt, 672 Main St., Willimantic
ice-President: David H. Bates, 28 Front St., Putnam
ecretary: Brae Rafferty, 807 Main St., Willimantic
ouncilor: Karl T. Phillips, 66 Main St., Putnam

Annual Meeting, Third Thursday in April
Semi-Annual Meeting, Third Thursday in October

ABINGTON

948 Valentine, Bruce, Eliza F. Clark Memorial Center

HAMPTON

914 Marsh, Arthur Drought

KILLINGLY

Danielson

935 Chartier, Gerard Marcel, 148½ Main
928 Garcin, Cecil Redvers, 7 Broad
940 Laakso, Andrew Olavi, 39 Broad
909 Perreault, Joseph Napoleon, 43 Main
919 Tanner, Warren Avery, 36 Academy
920 Todd, Frank Paige, 178 Main

MOOSUP

940 Couture, Arthur Joseph, 19 South Main
946 Woodworth, John Albert, 1 Main

NORTH GROSVERNORDALE

948 Rowson, Walter, Jr.

PLAINFIELD

903 Chase, Arthur Alverdo, Railroad Ave.
933 Gulino, Angelo James

PUTNAM

942 Bates, David Hinrichs, 28 Front
934 Chapnick, Morton Herman, 168 Main
947 Dinolt, Robert, Bradley Theater Building
948 LaPalme, Leo, 158 Main
941 Margolick, Moses, 80 Main
921 Phillips, Karl Tristram, 66 Main
930 Prosser, Florence Dean, 158 Main
922 Russell, John Jarvis, Bridge and Main
934 Shepard, William Mac, 66 Main

WINDHAM

Willimantic

1935 Arnold, Morton, 29 North
1947 Baker, Conrad Stolzenbach, Windham Community Hospital
1939 Basden, Edward Herbert, 820 Main
1939 Carter, George Howard, 29 North
1901 Girouard, Joseph Arthur, 19 Union
1928 Kinney, Kenneth Kyle, 29 North
1940 Little, Mervyn Henry, 715 Main
1940 Little, Olga A. G., 715 Main
1947 Maurer, William Spooner, 670 Main
1925 Ottenheimer, Edward Joseph, Windham Community Hospital
1932 Rafferty, Brae, 807 Main
1916 Riordan, Michael Davitt, 59 Church
1937 Rothblatt, Reuben, 672 Main
1914 Smith, Fred Morse, 736 Main
1929 Spector, Nathan, 59 Church
1935 Vernon, Sidney, 8 Willard

WOODSTOCK

East Woodstock

1913 Pike, Ernest Reginald

OUT OF COUNTY

1946 Dayton, Neil Avon, State Training School, Mansfield Depot
1946 Flynn, Herbert Lawrence, Mansfield State Training School, Mansfield Depot
1932 Gilman, Ralph Lawrence, Storrs
1896 Hills, Laura Heath, Winter Haven, Florida
1942 Leary, Deborah Cushing, 284 Mix Ave., Hamden, Conn.
1941 Lehndorf, Peter, Massachusetts Memorial Hospital, 750 Harrison Ave., Boston, Mass.
1946 Moxon, Gail Fitch, State Training School, Mansfield Depot
1936 Roch, George E., Veterans Administration, 95 Pearl St., Hartford
1936 Roy, Joseph Lambert, 327 Greenwood Dr., West Palm Beach, Florida
1944 Welt, Louis Gordon, 789 Howard Ave., New Haven, Conn.
1947 Whalin, Marion Louise, Storrs

ASSOCIATE MEMBERS

1941 Burr, Harold Saxton, 333 Cedar, New Haven
1948 Crankshaw, Charles William, Pleasant Valley Rd., South Windsor
1947 Darling, George Bapst, Woodbridge Hall, Yale University, New Haven
1941 Fulton, John Farquhar, 333 Cedar, New Haven
1941 Haggard, Howard W., 4 Hillhouse Ave., New Haven
1942 Hamilton, James A., University of Minnesota, Minneapolis, Minn.
1941 Hiscock, Ira Vaughn, 215 Highland, New Haven
1941 Long, Cyril Norman Hugh, 333 Cedar, New Haven
1941 Mickle, Friend Lee, P. O. Box 1139, Hartford
1943 Schneider, Edward Christian, Wesleyan University, Middletown

ALPHABETICAL ROLL OF MEMBERS

With date and place of graduation

Aaronson, M. S., Univ. & Bellevue '13, Ansonia
Abrahams, M., Tufts '31, New Canaan
Abrahamson, R. H. McGill '30, Bridgeport
Abrashkin, M. D., Maryland '32, Coral Gables, Florida (New Haven County)
Adams, F. S., Yale '25, Canaan
Adams, A. J., Indiana '38, Torrington
Adams, M., Johns Hopkins '29, Greenwich
Adzima, J. M., Maryland '27, Bridgeport
Affinito, T., McGill '31, Meriden
Agnew, R. R., Yale '08, Norwich
Agrin, A., Tufts '44, Norwich
Aiello, L. J., Boston '35, New Haven
Akerson, I. B., Iowa '25, Bridgeport
Albamonti, M. J., Tufts '38, Norwich
Albom, J. J., Columbia '39, Brooklyn, N. Y. (New Haven County)
Alderman, I. S., Columbia '19, New Haven
Aldwin, F. J., Yale '32, Stamford
Alexander, S. J., Univ. & Bellevue '32, Middletown
Allen, E. P., Yale '24, New Haven
Allen, G. F., McGill '37, Hartford
Allen H. E., Bowdoin '19, Waterbury
Allen, J. C., Hahnemann '39, New Haven
Allen, M. F., Med. Chi., Phila. '95, New Haven
Allen, M. M., Woman's Medical '35, Hartford
Allen, W. M., Johns Hopkins '20, Hartford
Alley, R. D., Yale '43, New Haven
Alling, A. N., Columbia '91, New Haven
Allinson, M. J. C., Arkansas '45, New Haven
Alpert, M., Yale '28, Bridgeport
Alu, A. F., Yale '20, Ansonia
Amarant, L., Vienna '32, Bridgeport
Amatruda, F. G., Yale '23, New Haven
Ames, W. G., Columbia '38, Essex
Amos, I. L., McGill '26, Danbury
Amoss, H. L., Harvard '11, Greenwich
Anderson, C. W., Harvard '34, Greenwich
Andrews, E. M., Harvard '30, Hartford
Andrus, O. B., Univ. & Bellevue '32, Devon
Antell, M. J., Vermont '29, Bridgeport
Anton, M. C., Marquette '39, Stratford
Antupit, L., Jefferson '23, Hartford
Appell, H. S. Tufts '27, New Haven
Appell, P. H., Univ. & Bellevue '23, Bristol
Apsel, A., Long Island '18, Bridgeport
Apter, H., George Washington '34, Hartford
Apuzzo, A. A., Tufts '36, Bridgeport
Archambault, H. A., Tufts '27, Taftville
Arnold, H. B., Yale '26, New Haven
Arnold, H. S., Yale '03, Woodbridge
Arnold, M., Harvard '29, Willimantic
Arons, M. R., Maryland '30, Hartford
Arrick, M. S., Long Island '43, New Haven
Ashcroft, A. D., Columbia '35, Stratford
Ashley, H. C., Virginia '26, Winsted
Atha, H. G, Tufts '34, Tuscon, Arizona (Litchfield County)
Atkins, S. M., Tufts '22, Waterbury
Aube, L. A., McGill '43, Bridgeport
Audet, C. H., Maryland '17, Waterbury
Ayres, P. B., Toronto '32, Cos Cob

Backer, M., Yale '24, Bridgeport
Backhus, L. C., Syracuse '33, Waterbury
Bader, G. B., Columbia '20, Washington Depot
Backus, H. S., Long Island '03, Hartford
Bailey, N. H., P. & S., Balt. '11, Hartford
Baker, C. S., Yale '34, Willimantic
Baker, P. G., Vermont '33, Winsted
Bakunin, M. I., Jefferson '32, Bridgeport
Balletto, V., Tufts '33, East Haven
Banay, R. S., Budapest '20, New York City (New Have County)
Bancroft, H. A., Albany '16, Hartford
Banks, D. T., Fordham '12, Bridgeport
Bannon, F. M., Vermont '28, Stamford
Baptist, V., Boston '42, Terryville (Hartford County)
Barald, F. C., Boston '36, Jefferson Barracks, Mo. (Ne Haven County)
Barber, W. L., Jr., Univ. & Bellevue '07, Waterbury
Barber, R. R., Vermont '30, Stamford
Barbour, C. M., Jr., McGill '38, Hartford
Barbour, P. H., Jr., Yale '41, Farmington
Barker, C., Dartmouth '13, New Haven
Barker, D. C., Maryland '40, Fairfield
Barker, N. J., Toronto '26, Hartford
Barnes, F. H., N. Y. Homeo. '96, Stamford
Barney, W. E., Yale '35, Milford
Barnum, C. G., Yale '11, Groton
Barrett, W. J., Maryland '04, New Haven
Barry, J. C., Boston '33, Manchester
Barstow, R. I., Jefferson '33, Norfolk
Bartlett, C. J., Yale '95, New Haven
Barton, P. N., Harvard '39, Bristol
Basden, E. H., Tufts '33, Willimantic
Baskin, A. H., Minnesota '32, Elmwood
Bassin, A. L., Rochester '30, New Haven
Batelli, C. F., Yale '28, New Haven
Bates, D. H., Long Island '39, Putnam
Battista, A. W., Tufts '24, New Haven
Bausch, C. P., Tufts '29, Hartford
Beach, C. T., Yale '05, Hartford
Beaman, G. B., Harvard '34, Stamford
Beardsley, L. G., Yale '17, Newington
Beatman, I., Tufts '27, Hartford
Beatrice, A. A., Tufts '29, Bristol
Beauchamp, M. F., Vermont '43, New Haven
Beauchemin, J. A., Montreal '25, Middletown
Beaudry, J. H., McGill '13, Bridgeport
Beck, E. C., Yale '26, South Norwalk
Beck, F. G., Yale '03, New Haven
Beck, S. H., Rochester '34, Bridgeport
Becker, J., Univ. & Bellevue '29, New London
Beckett, R. S., Yale '40, Hartford
Beckwith, D. M., Harvard '34, East Haven
Beebe, J. T., Columbia '38, Hartford
Behan, E. J., McGill '22, New Haven
Beizer, E., Long Island '30, Hartford
Bell, J. S., Illinois '28, Ridgefield
Bellach, H., Long Island '33, New Britain
Bellew, R. F., Tufts '37, Bridgeport
Beloff, J. S., Columbia '43, Meriden
Benedict, M. K., Johns Hopkins '19, New Haven
Benjamin, H. W., Rush '33, New Britain
Benoit, R. J., Georgetown '26, New Britain
Benton, P. E., Columbia '34, Mt. Gilead, Ohio (Fairfiel County)
Bergendahl, H. A., Tufts '33, Norwich

Berger, A. J., Harvard '40, Minneapolis, Minn. (Hartford County)
Bergin, T. J., Yale '99, Cos Cob
Berlowe, M. L., Long Island '34, New Haven
Berman, B. A., Tufts '34, Waterbury
Berman, H. L., Yale '15, New Haven
Berneike, R. R., Western Reserve '41, New Haven
Bernstein, A., Yale '08, Bridgeport
Bernstein, D. J., Vermont '33, New Britain
Bernstein, L., U. of Berne '36, Hartford
Berwick, P., N. Y. Med. Coll. '38, Moodus
Besser, E. L., Johns Hopkins '37, Manchester
Bestor, E. L., N. Y. Homeo. '07, Hartford
Bevans, T. F., Minnesota '03, Waterbury
Bidgood, C. Y., Virginia '20, Hartford
Biehn, D. M. F., Queen's '37, Fairfield
Biehn, S. L., Toronto '26, Fairfield
Bielecki, C. E., Tufts '39, Norwich
Bienkowski, J. G., Harvard '35, Torrington
Bingham, C. T., Columbia '32, Hartford
Biondi, B., Tufts '38, New Haven
Biram, J. H., Cornell '10, West Hartford
Bird, F. S., Vermont '33, Bristol
Birge, H. L., Pennsylvania '33, Hartford
Birnbaum, H. B., Royal Coll. England '35, Madison
Birney, T. P., Northwestern '39, Bridgeport
Bisharat, M. H., Amer. Univ. of Beirut '43, Torrington
Bishop, C. C., Yale '30, New Haven
Bissell, A. H., Cornell '16, Stamford
Bixby, H., Tufts '35, Bismarck, N. D., (Middlesex County)
Bizzozero, O. J., Vermont '27, Waterbury
Blaine, G. B., Jr., Columbia '43, South Kent
Blake, E. M., Yale '06, New Haven
Blake, F. G., Harvard '13, New Haven
Blanchard, D. L., Yale '31, Branford
Blank, E. H., Vermont '25, New London
Blass, G., Vienna '24, Stamford
Blau, R., Friedrich Wilhelms '20, Waterbury
Blinkoff, J. J., Berne '37, Torrington
Bliss, S. P., Tufts '39, Dallas, Texas (Fairfield County)
Blodinger, I. E., Yale '25, New Haven
Blogoslawski, W. J., Georgetown '27, New Britain
Bloom, D. I., Tufts '35, Thompsonville
Bloomberg, M., Tufts '24, Waterbury
Bluestone, D. H., Syracuse '12, Naugatuck
Blumenthal, E. J., Long Island '32, Ansonia
Blumer, G., Cooper '91, San Marino, California (New Haven County)
Boardman, A. K., Pennsylvania '99, New Haven
Bobrow, A., Berne '36, Hartford
Bodie, J. A., Tufts '24, New Haven
Bodie, W. J., Georgetown '29, Branford
Bogin, M., Yale '26, Bridgeport
Boguniecki, S. J., Harvard '40, Meriden
Boisvert, P. L., Rochester '34, New Haven
Bonner, R. A., Maryland '12, Waterbury
Bonner, R. A., Jr., Maryland '38, Waterbury
Booe, J. G., Med. Coll. Va. '19, Bridgeport
Booth, J. D., Columbia '26, Danbury
Borkowski, B. J., Georgetown '28, Bristol
Bornemann, C., N. Y. Med. Coll. '40, Canaan
Boshnack, M., N. Y. Medical Coll. '43, Stamford
Botsford, C. P., Yale '94, Hartford
Bowen, F. D. T., Maryland '42, Hartford
Bowen, J. J., Jr., Maryland '41, Waterbury
Bowman, S. H., Hahnemann, Chicago '13, Stamford
Boyarsky, H. M., Tufts '31, Wallingford
Boyd, H., Harvard '21, South Manchester
Boyd, R. B., Tufts '41, Wallingford
Brackett, A. S., Jefferson '95, Bristol
Brackin, J. T., Jr., Penn. '36, Hines, Ill. (Hartford County)
Bradeen, F. B., Pennsylvania '99, Essex
Bradley, E. T., Cornell '36, Norwalk
Brainard, C. B., Yale '98, West Hartford
Brandon, K. F., Toronto '32, Hartford
Branon, A. W., Jefferson '13, Hartford
Braun, R., Vienna '29, Bridgeport
Brayton, H. W., Harvard '11, Hartford
Breck, C. A., Yale '30, Wallingford
Brecker, F. W., Tufts '28, Hartford
Brennan, E. L., Natl. Univ., Ireland '23, Hartford
Brennan, P. J., Yale '07, Waterbury
Bretzfelder, K. B., Jefferson '16, New Haven
Brewer, A. E., N. Y. U. '41, Salisbury
Brewer, F., Columbia '20, Bloomfield (Fairfield County)
Brewer, T. F., Yale '26, Hartford
Brewster, W. B., Jr., Harvard '42, Hartford
Brezina, P. S., Yale '40, Bristol
Bria, W. F., Rome '34, Cos Cob
Bridge, J. L., Harvard '03, Hazardville
Brier, H. D., N. Y. U. '34, Bridgeport
Bristoll, D. A., Pennsylvania '27, New Britain
Brochu, E. D., Boston '33, Danbury
Brockway, D. W., Long Island '43, Bristol
Brodsky, M. E., Northwestern '26, Bridgeport
Brody, B. S., Yale '28, New Haven
Bronson, W. T., University & Bellevue '98, Danbury
Brooks, P. L., McGill '32, Bridgeport
Brophy, E. J., Yale '04, Norwichtown
Brosnan, J. F., Tufts '30, New London
Brown, A. S., Yale '26, Waterbury
Brown, M. R. S., Temple '43, Meriden
Brown, P. H., Vermont '26, Stamford
Brown, P. N., Hahnemann '43, South Meriden
Brown, R. J., Maryland '44, Stratford
Browne, F. A., Johns Hopkins '20, Hartford
Bruckner, W. J., Cornell '33, New Haven
Bruno, J. J., Hahnemann '35, New Haven
Bruskin, C. E., Leipzig '32, Hartford
Bryan, K. M., Hering '04, Norwich
Buccheri, F. S., Tufts '35, New Britain
Bucciarelli, J. A., Temple '31, Norwalk
Buchan, R. F., McGill '42, New Haven
Buck, B. J., Harvard '26, Hartford
Buckhout, G. A., Tufts '35, Bridgeport
Buckley, J. L., Tufts '40, Torrington
Buckley, R. C., Yale '24, Hartford
Buckley, J. W., Georgetown '33, Bridgeport
Buckley, W. E., Boston '33, Middletown
Buckmiller, F. C., Vermont '14, Bridgeport
Buda, G. E., Zurich '37, Stratford
Budau, J. H. D.. Yale '00, Rockledge, Fla. (New Haven County)
Bullen, B. W., Jr., Cornell '41, Greenwich
Bumstead, J. H., Johns Hopkins '23, New Haven
Bunnell, W. W., Yale '29, Farmington
Bunting, H., Harvard '36, New Haven
Buol, R. S., Harvard '23, New Britain
Burack, J. O., Tufts '39, South Norwalk
Burgess, F. H., George Washington '40, Ridgefield
Burgdorf, A. L., Rush '31, Bloomfield
Burke, F. H., Georgetown '31, Rockville
Burke, J. F., Yale '31, Waterbury
Burlingame, C. C., Gen. Med. Coll. Chicago '08, Hartford
Burness, S. H., Vermont '38, Hartford
Burnie, C. A., Yale '35, Danbury

Burns, B. J., Georgetown '18, Bridgeport
Burns, F. M., Columbia '39, Shelton
Burns, G. D., Yale '25, Derby
Burns, M. M., Texas '27, West Hartford
Butler, N. G., Tufts '24, Hartford
Byrne, D. W., Columbia '27, Hartford

Cabaniss, J. T., Columbia '15, Hartford
Cacace, V. A., Loyola '39, Baltimore, Md (Fairfield County)
Calabresi, M., Florence '26, New Haven
Caldwell, D. M., McGill '19, South Manchester
Calef, B., St. Louis '32, Elmwood
Calhoun, H. A. Tufts '34, Higganum
Callahan, J. W., P. & S., Balt. '11, Norwich
Callender, E. F., Yale '12, Chester
Calverley, E. T. T., Woman Med. Pa. '08, Hartford
Calvin, C. V., Harvard '16, Bridgeport
Camarda, A. L., Naples '41, Bridgeport
Cammann, O. DeN., Columbia '33, New Canaan
Campbell, H. B., Pennsylvania '09, Norwich
Campbell, R. H., Wayne '35, West Hartford
Campbell, S., Vermont '23, Wallingford
Canby, J. E., Jefferson '27, West Hartford
Caney, W .H., Albany '41, Watertown
Canfield, N., Michigan '29, New Haven
Capacelatro, A., Tufts '19, New Haven
Caplan, H., Yale '27, Meriden
Caplan, M., Louisville '33, Meriden
Capobianco, A. P., N. Y. Med. Coll. '40, Bridgeport
Cappelletti, A. J., Jefferson '46, Waterbury
Cappiello, S., Tufts '19, Hartford
Carangelo, J., Tufts '38, Hartford
Carbone, W. C., Georgetown '33, Hamden
Cardone, M. J., Vermont '37, Bridgeport
Carelli, G. F., Yale '11, New Haven
Carey, T. B., Albany '44, Douglas, Arizona (Middlesex County)
Carey, T. C., Yale '28, Hartford
Carey, W. C., Columbia '33, Meriden
Carignan. R. Z., Georgetown '40, East Hartford
Carlin, C. H., Michigan '96, Torrington
Carlson, C. E., Maryland '37, New Britain
Carlson, R. I., Yale '39, New Haven
Carniglia, E. F., Harvard '29, Hartford
Carpenter, R. M., Loyola '16, Stamford
Carpentieri, A. L., N. Y. Med. Coll. '38, Waterbury
Carpinella, M. J., Rochester '32, Branford
Carroll, J. E., Boston '25, Hartford
Carroll, P. R., Jr., Georgetown '29, Bridgeport
Carroll, W. E., Dartmouth '14, Orange, N. J. (New Haven County)
Carrozzella, J. C., Long Island '28, Wallingford
Carter, E. B., Johns Hopkins '11, Hartford
Carter, G., Johns Hopkins '28, Greenwich
Carter, G. H., Columbia '35, Willimantic
Carvey, E. V., Yale '35, Wethersfield
Carwin, J. L., Meharry '32, Stamford
Casagrande, J. J., St. Louis '32, Ansonia
Case, E. P., Michigan, '11, West Hartford
Case-Downer, M., Boston '29, Hartford
Caserta, S. J., Georgetown '37, Bridgeport
Cashman, J. L., Hahnemann '37, North Haven
Cassone, R., Vermont '41, Stamford
Castaldo, L. F., Tufts '37, Bridgeport
Castiglione, F. M., N. Y. Med. Coll. '42, New Haven
Catalan, J. O., Meharry '19, New Haven
Caulfield, E. J., Johns Hopkins '20, Hartford
Cavaliere, V. J., N. Y. U. '43, Bridgeport
Celentano, L. E. H., Hahnemann '30, New Haven
Cenci, V. P., Tufts '29, Hartford
Centrone, P. A., Columbia '37, New Haven
Cerrone, L. J., Bologna '38, New Haven
Chait, S. A., Nebraska '40, Torrington
Chapnick, M. H., Jefferson '32, Putnam
Chartier, G. M., Boston '33, Danielson
Chase, A. A., Harvard '01, Plainfield
Chase, C. C., Vermont '24, Middletown
Chasnoff, J. A., Long Island '36, West Haven
Chaucer, N. G., Columbia '41, Stamford
Cheney, C. B., Yale '41, New Haven
Cheney, G. P., Md. Coll. Med. '13, New London
Cheney, M. L., Vermont '17, Bridgeport
Chernaik, S. J., Jefferson '16, New Britain
Chester, L. L., Vermont '38, Hartford
Childs, A. E., University & Bellevue '96, Stanfield, Oregon (Litchfield County)
Chobian, J. A., Loyola, '33, Seymour
Chotkowski, L. A., Yale '42, Kensington
Chou, T. P., Hunan-Yale '22, Stamford
Ciccarelli, A. W., Hahnemann '42, Bristol
Cipriano, A. P., Long Island '41. New Haven
Claffey, M. F., Vermont '14, Bristol
Claiborn, L. N., Washington '27, New Haven
Clancy, J. J., Yale '35, Hartford
Claps, L. V., N. Y. U. '40, Greenwich
Clark, B. B, Cornell '37, New Britain
Clark, M. H., Women's Medical '33, New Haven
Clark, W. T., Queen's '34, Bridgeport
Clarke, C. C., Yale '32, New Haven
Clarke, H. M., Rochester '39, New Britain
Clarke, R. DeB., Johns Hopkins '08, Hartford
Clarke, W. I., Harvard '41, Meriden
Clason, F. P., Harvard '15, Hartford
Cleary, H. J., Tufts '29, Watertown
Clement, D. H., Harvard '35, New Haven
Clifford, M. L., Colorado '33, Hartford
Clifton, H. C., Pennsylvania '01, Bloomfield
Climan, M., Columbia '15, Hartford
Climo, S., Ohio '29, New Haven
Close, J. F., Columbia '25, Greenwich
Clow, H. L., Tufts '14, Newtown
Coates, S. P., Maryland '34, Suffield
Cobb, A. E., Yale '98, Canaan (Hartford County)
Cobey, J. F., Yale '16, New Haven
Cody, G. R., Georgetown '36, South Norwalk
Cody, T. P., Long Island '36, New Canaan
Coffey, J. R., Yale '07, New Haven
Coffin, S. F., Jr., Rochester '43, Darien
Cofrances, L. W., Jefferson '23, New Haven
Cogan, G. E., Georgetown '23, Hartford
Cognetta, A. B., N. Y. U. '46, Stamford
Cognetta, J. J., Vermont '36, Stamford
Cogswell, E. S., Harvard '12, Hartford
Cogswell, L. P., Harvard '33, Hartford
Cohane, T. F., Yale '97, New Haven
Cohen, D. J., Yale '32, Meriden
Cohen, L. H., Yale '31, New Haven
Cohen, W., Yale '23, New Haven
Cohn, S. H., Boston '34, Hartford
Colburn, R. F., Vermont '37, Stamford
Cole, C. H., Yale '32, Waterbury
Cole, M. J., St. Bartholomew's '39, Hartford
Colett, I. V., Vienna '38, Norwich
Collins, J. O., Baylor '29, Waterbury
Collins, W. F., Yale '04, New Haven
Colmers, R. A., Vienna '37, Stamford
Colwell, H. S., Johns Hopkins, '14, New Haven
Combes, J. DeR., Long Island '17, Salisbury

Comfort, C. W., Jr., Yale '11, New Haven
Compson, F. E. M., Boston '20, Middletown
Comstock, E. R., Tufts '33, New London
Conklin, C. S., Fordham '16, Bridgeport
Conklin, C. T., Jr., Vermont '41, Thomaston
Conlon, W. L., Jefferson '36, Manchester
Conner, E. D., Long Island '43, Fairfield
Connolly, A. J., Georgetown '28, New Haven
Connolly, J. P., Georgetown, '36, Stamford
Connor, G. J., Rochester '39, New Haven
Connor, G. M., Boston '35, Plantsville
Connor, J. J., Yale '30, Hartford
Connors, E. R., Boston '31, Bridgeport
Conroy, M. J., Yale '20, Meriden
Conte, H. A., Long Island '12, New Haven
Conte, M. G., Naples '35, New Haven
Conway, D. F., Jr., Columbia '37, New Haven
Conway, H., Cincinnati '28, New York (Fairfield County)
Cook, G. F., Tufts '23, Plainville
Cook, R. J., Johns Hopkins '13, New Haven
Coppeto, C. J., Marquette '39, Waterbury
Coppola, E. A., Long Island '10, Waterford
Corbett, H. J., Tufts '29, Waterbury
Corbett, W. T., Hahnemann '42, Long Hill
Corcoran, M. A., Tufts '30, Hartford
Corey, W. VanA., George Washington '33, Hamden
Cornelio, F. J., Georgetown '34, Winsted
Cornwell, P. M., Yale '34, Hartford
Corradino, C. L., Tufts '29, New Haven
Corridon, J. D., Georgetown '28, South Norwalk
Corwin, D. B., Syracuse '32, Norwalk
Coshak, M., Boston '37, Waterbury
Costanzo, J. J., Illinois '05, Stamford
Costello, H. N., Johns Hopkins '10, Hartford
Cotterio, T., Yale '26, Waterbury
Couch, F. H., Yale '30, Cromwell
Couch, M. W., Minnesota '27, Cromwell
Couture, A. J., Boston '32, Moosup
Cox, M. E., Cincinnati '36, Waterbury
Cox, R. B., McGill '02, Collinsville
Coyle, B. J., Georgetown '18, Windsor Locks
Cozzolino, E. N., Harvard '33, West Haven
Craig, G. M., Harvard '20, Middletown
Craighill, M. D., Johns Hopkins '24, Topeka, Kansas (Fairfield County)
Cramer, S. L., N. Y. Medical '41, Hartford
Crampton, C. B., Yale '37, Middletown
Crandall, B. B., Wisconsin '34, Mystic
Crane, J. E., Vermont '39, Stamford
Crane, R. W., Yale '05, Stamford
Crawford, G., Harvard '38, Centerbrook
Crawley, G. A., Temple '28, West Hartford
Creadick, A. N., Pennsylvania '08, New Haven
Creaturo, N. E., Boston '31, Bridgeport
Cressy, N. L., Yale '39, Newington (New Haven County)
Crispell, L. S., Yale '44, New Haven
Crispin, M. A., Temple '41, Bridgeport
Crosby, E. H., Yale '28, Hartford
Cullen, J. R., Georgetown '36, Hartford
Culotta, C. S., Yale '28, New Haven
Cunningham, J. M., Texas '26, Hartford
Cunningham, R. D. M., Yale '30, Stamford
Curley, W. H., Cornell '08, Bridgeport
Curley, W. H., Jr., Cornell '38, Bridgeport
Curnen, E. C., Jr., Harvard '35, New Haven
Curran, H. J., Tufts '24, Waterbury
Curran, P. J., Columbia '01, Bridgeport
Curran, T. L., Boston U. '39, Hartford
Curtis, A. K., Tufts '05, East Hartford
Curtis, B. H., Columbia '36, Hartford
Curtis, W. B., Columbia '34, New Haven
Cushman, L. A., Harvard '24, West Hartford
Cutler, H. S., St. Louis '37, New Haven
Czyz, S. I., Loyola '43, Bristol
D'Alessio, C. M., Maryland '37, Derby
Daley, L. W., McGill '30, New Britain
Dallas, M., Boston '22, New Haven
Dalmain, W. A., St. Louis '37, Bristol
Dalton, G. H., Yale '12, New Britain
Daly, C. W., P. & S., Balt. '10, Hartford
Daly, J. L., N. Y. U. '33, Norwich
Daly, W. P., Georgetown '17, Hartford
D'Ambruoso, D. C., Columbia '36, Derby
Damiani, R. A., Tufts '33, Waterbury
D'Amico, J., Rome '37, New Haven
D'Amico, M., Yale '31, New Haven
Danaher, T. J., Yale '28, Torrington
Danburg, D. S., Louisville '39, Norwich
D'Andrea, F. H., Yale '29, Stamford
Darrow, D. C., Johns Hopkins '20, New Haven
Darrow, J. E., Tufts '28, New Britain
Dart, F. B., Maryland '23, Niantic
Dautrich, A. W., Yale '39, Litchfield
Davenport, A. K. P., South Carolina '03, Hartford
Davis, D. A., Hahnemann '36, Derby
Davis, G. B., Vermont '24, Milford
Davis, J., Cincinnati '34, Stamford
Davis, J. B., Kansas '33, New Haven
Davis, J. E., Johns Hopkins '19, Hartford
Davis, J. S., Boston U. '36, South Norwalk
Davis, T. F., Tufts '21, Fairfield
Davol, R. T., Columbia '41, Greenwich
Dawson, L. M., Queen's '09, Unionville
Day, F. L., Bellevue '93, Bridgeport
Day, H. L., Yale '34, New Haven
Dayton, A. B., Johns Hopkins '15, New Haven
Dayton, N. A., Ohio '15, Mansfield Depot (Windham County)
Dayton, T. R., Harvard '25, Wallingford
Dean, S. R., Michigan '34, Stamford
DeAngelis, L., Virginia '36, New London
DeBonis, D. A., Naples '90, Hartford
DeCristoforo, R., Tufts '37, Waterbury
DeForest, G. K., Yale '32, New Haven
DeKlyn, W. B., Temple '41, Danbury
de la Vergne, P. M., McGill '35, Meriden
Delevett, A. F., Johns Hopkins '40, Bridgeport
Delligan, F. W., Georgetown '41, Hartford
Delohery, C. L., Temple '26, Danbury
DeLuca, H. R., George Washington '16, Bridgeport
DelVecchio, L. F., Georgetown '31, Bridgeport
Deming, A. S., Harvard '40, Hartford
Deming, C. D., Johns Hopkins '10, Hartford
Deming, C. K., Columbia '17, New Haven
Deming, C. L., Yale '15, New Haven
Deming, E. A., Johns Hopkins '08, Hartford
Deming, N. L., Columbia '93, Old Saybrook
Denne, T. H., Vermont '05, West Hartford
Dennehy, W. J., Yale '18, New Haven
DePasquale, F. L., Pennsylvania '26, Hartford
DePasquale, J. A., Pennsylvania '36, Hartford
Deren, M. D., Syracuse '33, Bridgeport
DerKach, S. L., Hahnemann '40, Greenwich
DeRosa, S. F., Jefferson '24, Meriden
Desmond, C. T., Boston U. '38, Hartford
Desmond, W. F., Yale '25, Newtown
D'Esopo, J. N., McGill '31, New Haven
de Suto-Nagy, I. K., Royal Hung. '15, New Haven

Deutsch, J. V., Long Island '36, Southbury
Devenis, M. M., Yale '19, Waterbury
DeVito, M. J., Vanderbilt '28, Hartford
Devitt, E. K., Maryland '07, Old Lyme
DeWitt, E. N., Pennsylvania '17, Bridgeport
Diamond, E. H., Breslau '32, Norwalk
DiBlanda, H. A., N. Y. Medical '32, Westport
Dichter, C. L., Md. Coll. Med. '05, Stamford
Dichter, I. S., Jefferson '31, Stamford
Dickinson, F. McL., Columbia '05, Rockville
Dickinson, G. H., Vermont '46, Meriden
DiFrancesco, L. P., Tufts '31, Stamford
DiGiandomenico, A. T., St. Louis '41, Meriden
Dignam, B. S., Yale '35, Thompsonville
Dillon, J. H., Yale '04, Waterbury
DiLorenzo, S. F., Tufts '43, Waterbury
Dinan, H. P., Tufts '38, Stratford
Dinolt, R., Vienna '30, Putnam
Dion, A. J., Tufts '28, Hartford
Dion, J. A., Georgetown '37, Hartford
Dionne, U. A., Tufts '30, Waterbury
Diskan, A. E., Temple '37, Manchester
DiStasio, F., Maryland '33, New Haven
Dixon, H. C., Bowdoin '17, Norwich
Dobbs, W. G. H., Rochester '34, Torrington
Dobkins, J. J., Toronto '39, Stamford
Dodd, B., Columbia '33, Hartford
Doerr, W. J., Erlangen '40, Hartford
Doff, S. D., Long Island '39, New Haven
Dolce, J. A., South Carolina '25, Buffalo, N. Y. (Hartford County)
Donadeo, J., Bologna '42, Bridgeport
Donnelly, S. P., Georgetown '24, New Britain
Donnelly, W. A., Cornell '40, Bridgeport
Donnelly, W. A., Vermont '34, Hartford
Donner, S., Cornell '33, Hartford
Donohue, B. F., Yale '03, Bristol
Donohue, J. D., Baltimore '09, Uncasville
Donohue, J. J., P. & S., Balt. '96, Norwich
Donovan, W. F., Boston '31, Hartford
Dorian, G. D., Hahnemann '39, New Britain
Dorian, E., Maryland '37, New Britain
Dorion, R. H., Vermont '32, Stamford
Douglass, E. L., Long Island '16, Groton
Downs, E. F., Johns Hopkins '37, Bronxville, N. Y. (Litchfield County)
Dray, E. J., Jefferson '09, New Britain
Dreher, A. C., Yale '23, Waterbury
Dreher, S. M., Temple '37, Derby
Dressler, M., Long Island Coll. Med. '27, Hartford
Driscoll, J. J., Vermont '25, Danbury
Driscoll, W. T., P. & S., Balt. '12, Norwich
Drobnes, S., Freiburg '37, Norwich
DuBois, F. S., Rush '31, New Canaan
DuBois, R. L., Maryland '35, Waterbury
Ducker, S. R., Duke '44, Newtown
Dudac, T. W., Georgetown '33, Southington
Duennebier, H. W., Tufts '40, Niantic
Duffy, L. T., Tufts '34, Hartford
Duffy, V. P., Maryland '17, Grafton, W. Va. (New Haven County)
Duffy, W. C., Johns Hopkins '14, New Haven
Duksa, W. J., Georgetown '37, Hartford
Dunham, E. C., Johns Hopkins '18, Washington, D. C. (New Haven County)
Dunn, F. M., Baltimore '08, New London
Dunn, M. L., N. Y. U. Coll. Med. '43, New Britain
Dunne, E. P., Maryland '18, Unionville
Durkee, R. E., Jr., Harvard '36, Hartford
Durlacher, S. H., Yale '38, Bel Air, Md. (New Haven County)
Dushane, J. E., Tufts '36, Hartford
Duzmati, P. P., Jefferson '36, Bridgeport
Dwyer, C. E., Georgetown '25, Waterbury
Dwyer, H. L., Jr., Northwestern '43, New Haven
Dwyer, P. J., University & Bellevue '97, Waterbury
Dwyer, W., Johns Hopkins '13, Hartford
Dyer, C. E., Tufts '28, New London

Earle, B. B., Rush '30, Glastonbury
Ebers, T. M., Nebraska '31, Hartford
Eckert, G. R., Tufts '33, Danbury
Eddy, M. H., Harvard '35, Bridgeport
Edgar, K. J., Oregon '31, Bridgeport
Edlin, C., Tufts '25, Waterbury
Edson, D. H., Vermont '42, Danbury
Edson, R. C., Jefferson '31, Windsor
Edson, R. H., Cornell '35, Shelton
Egan, J. J., Maryland '07, Newington (New Haven Count
Egee, J. B., Hahnemann '34, Newtown
Eimas, A., Tufts '30, Bridgeport
Eisenberg, S. E., Rochester '39, New Britain
Elgosin, R. B., McGill '40, Hamden
Eliot, M. M., Johns Hopkins '18, Washington, D. C. (Ne Haven County)
Elkinton, J. R., Harvard '37, Hamden
Elliot, K. G., Tufts '26, Hartford
Elliott, F. G., Jr., Howard '40, Bridgeport
Elliott, J. R., Boston '32, Canaan
Ellis, F. D., Jr., Pennsylvania '18, New Britain
Ellis, L. G., Jefferson '20, Hartford
Ellis, W. A., Jefferson '40, Hartford
Ellison, F. S., Yale '34, Hartford
Ellison, M. M., Rochester '43, New Haven
Ellrich, D. L., Jefferson '28, Westport
Elmer, E. O., P. & S., Balt. '94, West Hartford
Elsberg, C. P., N. Y. Med. Coll. '33, Middletown (Hartfor County)
Ely, J. G., Harvard '23, Lyme
Ematrudo, F. R., Eclectic, Cinn. '21, Hamden
Emmett, F. A., Yale '02, Hartford
Enander, F. C., Tufts '22, New Britain
English, C. F., St. Louis '12, Winsted
Englehart, E. E., Strassburg '17, Hartford
Engstrom, W. W., Minnesota '39, New Haven
Epstein, B., Vienna '36, Danbury
Epstein, C. J., Yale '29, New Haven
Epstein, J. L., Yale '43, Portland
Errico, L., Yale '21, New Haven
Eskwith, I. S., Syracuse '40, Bridgeport
Esposito, J. J., Columbia '37, Bridgeport
Etkind, M. G., Maryland '33, New Haven
Evans, J. H., Boston U. '02, New Haven
Evans, T. S., Columbia '21, New Haven
Evarts, J., Columbia '29, Cornwall Bridge
Eveleth, M. S., Johns Hopkins '38, New Haven

Fabricant, S. E., Jefferson '19, Waterbury
Fabro, J. A., Tufts '37, Torrington
Fagan, F. J., Boston '38, New London
Fagan, F. X., Cornell '33, Hartford
Farland, V. L., Montreal '25, Hartford
Farmer, J., Chicago '40, Hartford
Fawcett, G. G., Cornell '15, South Norwalk
Fay, K. J., McGill '43, Hartford

ıy, W. J., Harvard '14, Hartford
eeney, T. M., Boston '36, Hartford
ekety, S. H., Tufts '30, Middletown
elding, H. A., Hahnemann '31, Stamford
elt, P. R., Dartmouth '10, East Hampton
elty, A. R., Johns Hopkins '20, Hartford
enney, P. W., Tufts '31, New Haven
erguson, H. K., N. Y. U. '32, New London
erguson, J. F., Jr., Yale '40, Wallingford
erguson, R. C., Yale '20, Rockville
errara, M., Marquette '35, Norwich
lson, R. M., Queen's '15, West Hartford
neke, C. L., Harvard '28, Stamford
ndorak, F. G., Georgetown '37, Bridgeport
ne, B., Jefferson '32, Stamford
ne, J., Pennsylvania '31, Stamford
nesilver, E. M., Johns Hopkins '24, Hartford
nk, L., Leipzig '23, Bridgeport
nkelstein, W., Harvard '34, Waterbury
nkelstone, B. B., P. & S., Balt. '10, Bridgeport
nley, G. C., Tufts '24, Hartford
nn, A. J., Bowdoin '21, Waterbury
nn, E. J., Yale '10, Shelton
nner, R. W., Duke '40, Middletown (New Haven County)
orito, J. A., Washington '37, New Haven
scher, A., Paris '36, Hamden
ischer, W. J. H., Yale '11, Milford
isher, J. G., Paris '11, Greenwich
isher, J. W., Wom. Med. Pa. '93, Middletown
iske, M., Boston '27, Stamford
iskio, P. W., Yale '27, New Haven
itzpatrick, E. E., Marvland '15, Waterbury
itzpatrick, E. J., McGill '42, New Haven
itzpatrick, W. F., Cornell '38, Norwalk
itzSimons, E. F., Tufts '24, New Haven
laherty C. V., Yale '10, Hartford
aherty, J. E., Georgetown '08, Rockville
lanagan, E. D., St. Louis '35, South Norwalk
leck, H. W., Jefferson '96, Stratford
leish, M. C., Tufts '40, Hartford
lvnn, C. T., Yale '11, New Haven
lvnn, H. A., Yale '27, New Haven
lynn, H. L., Vermont '29, Mansfield Depot, (Windham County)
lvnn, J. B., Jefferson '44, Meriden
lvnn, W. H., Maryland '16, Bristol
ogel, D. H., Duke '38, Stamford
olev, F. X., Boston '34, Bridgeport
oord, A., Columbia '41, New Haven
oote, C. J., Harvard '87, New Haven
ord, A. P., Wom. Med. Pa. '04, New Haven
ortier, N. L., McGill '43, Hartford
oster, F. W., Harvard '24, Meriden
oster, H. J., Hahnemann '43, Berlin
oster, J. H., Pennsylvania '17, Waterbury
oster, L. C., Harvard '23, New Haven
owler, G. A., Columbia '40, Sharon
owler, R. N., Columbia '34, Mystic
ox, G. F., Vermont '37, Hartford
ox, G. G., Harvard '34, Meriden
ox, J. C., Jr., Johns Hopkins '20, Hartford
ox, R. A., Creighton '37, Danbury
ranco, J. E., Tufts '40, Hartford
rank, H. S., Columbia '24, Middletown
razer, J. P., Rochester '39, Honolulu, Hawaii (New Haven County)
reedman, B. P., Yale '20, New Haven
reeman, A. C., Vermont '13, Norwich
reeman, D., Yale '24, New Haven
reeman, J. J., Temple '33, Newington
Freiheit, J. M., Yale '27, Waterbury
Friedberg, I. H., Tufts '37, Newington
Friedberg, S., Long Island '28, Stamford
Friedman, I., George Washington '31, Colchester
Friedman, I., Yale '33, New Haven
Friedman, N. H., Tufts '33, Stratford
Friedman, S., Boston '31, Newtown
Friend, A. E., Queen's '22, South Manchester
Friery, C. M., Boston '29, Hartford
Friesen, A. R., Nebraska '44, Philadelphia, Penn. (New Haven County)
Fritz, J., Vienna '15, Hartford
Frost, L. H., Vermont '13, Plainville
Frothingham, J. G., Harvard '35, New Canaan
Fry, C. C., Northwestern '24, New Haven
Fuldner, R. V., Columbia '33, New Haven
Fuller, R. H., Tufts '38, Simsbury
Funkhouser, S. P., Washington '19, Winsted
Furniss, H. W., Howard '91, Hartford
Furniss, W. E., Tufts '40, Bristol

Gaberman, D., Columbia '20, Hartford
Gade, C. J., Yale '10, Bridgeport
Gaetz, T. H., McGill '24, Shelton
Gaffney, C. B., Loyola '30, Bridgeport
Gaffney, J. J., Loyola '30, Danbury
Gaines, N. D., Illinois '41, Hartford
Galen, J. H., Long Island '42, Ansonia
Galinsky, D., Tufts '35, Hartford
Gallivan, J. N., Tufts '35, East Hartford
Gallo, F., Jefferson '34, Winsted
Gallo, W. J., Columbia '33, Cleveland, Ohio (Hartford County)
Gancher, J., Long Island '06, Waterbury
Gancher, R., Long Island '40, Waterbury
Gandy, R. A., Virginia '27, Stamford
Gandy, R. R., Pennsylvania '99, Stamford
Ganey, J. M., Columbia '04, New London
Garbelnick, D. A., Boston '17, Bridgeport
Garcia, A. C., Vermont '21, Moosup (New Haven County)
Garcin, C. R., McGill '25, Danielson
Gardner, C. W., Maryland '01, Bridgeport
Gardner, H. T., Yale '41, New York City (New Haven County)
Gardner, N. H., Tufts '34, East Hampton
Gardy, L. A., Bologna '37, Hartford
Garland, R. B., P. & S., Balt. '13, Hartford
Garlick, G. B., Yale '12, Bridgeport
Garofalo, M. L., Naples '35, New Haven
Garston, L. E., St. Louis '30, Torrington
Gaylord, C. W., Yale '15, Branford
Geck, O. F., Munich '25, Hartford (Middlesex County)
Geer, W. A., Yale '34, Bridgeport
Geetter, I. S., Jefferson '29, Hartford
Geib, H. A., Univ. & Bellevue '14, Milford
Geiger, A. J., Harvard '30, New Haven
Gencarelli, A. F., Buffalo '39, New Haven
Gendel, B. R., Tulane '35, Memphis, Tenn. (New Haven County)
Genovese, F. T., N. Y. U. '29, Danbury
Genovese, S., Cornell '11, Danbury
Gens, J. P., Yale '37, Norwalk
Gentile, A. L., Boston '29, New Haven
Genvert, H., Yale '36, Norwalk
Geraci, L. A., Columbia '17, New Haven
German, W. J., Harvard '26, New Haven
Gerow, G. H., Toronto '24, Westport
Gerstl, B., Vienna '27, Oakland, Calif. (New Haven County)
Gesell, A., Yale '15, New Haven

Gettings, J. A., Jefferson '16, New Haven
Gevalt, F. C., Jr., Columbia '40, Sharon
Giamarino, H. J., Maine '06, New Haven
Giannotti, C. C. Albany '18, West Haven
Gibson, C. B., Atlanta '14, Meriden
Gibson, D. F., Yale '27, Danbury
Gibson, F. D., Syraeuse '35, Hartford
Giddings, J. C., Vermont '43, Meriden
Giffin, L. A., Harvard '35, Hartford
Gilday, J. L., Eclectic, Cinn. '13, Bridgeport
Gildea, M. A., Buffalo '24, Bridgeport
Gildersleeve, G. H., Yale '23, Norwich
Giles, N. W., Vermont '21, Stamford
Gill, M. H., Yale '96, Hartford
Gillespie, H., Jefferson '34, Hartford
Gillette, A. T., Cornell '08, Woodbury
Gillis, G. E., Tufts '37, North Haven
Gills, W. L., Johns Hopkins '12, Hartford
Gillson, R. E., Vermont '29, New Haven
Gilman, R. L., Harvard '29, Storrs (Windham County)
Gilmer, R. J., Meharry '42, New Haven
Gilmore, H. R., Yale '31, Hamden
Giobbe M. E., Tufts '29, Torrington
Giorgio, N. A., Long Island '25, Hartford
Gipstein, E., Jefferson '31, New London
Girouard, J. A., Baltimore '99, Willimantic
Gissler, N. E., Yale '28, Middletown
Giuffrida, F., Tufts '37, Meriden
Giuliano, L. A., Tufts '32, South Norwalk
Giuliano, S., Tufts '30, Hartford
Glaser, W., Tufts '38, New Haven
Glass, G. C., Yale '31, Hartford
Glass, W. H., Duke '37, Hartford
Glaubman, H. M., Yale '27, Hartford
Glazer, M., Tulane '22, New Haven
Glazier, J. R., Harvard '22, West Hartford
Glike, F. P., Yale '41, Meriden
Glorig, A., Jr., Med. Evang. '37, Washington, D. C. (New Haven County)
Goddard, H. B., Harvard '24, East Hartford
Godfrey, E. J., Georgetown '15, Waterbury
Godfrey, E. W., Pennsylvania '37, Hartford
Godfried, M. S., Yale '36, New Haven
Goetsch, J. B., Rochester '38, New Haven
Goff, C. W., Illinois '24, Hartford
Gold, J. D., Columbia '91, Bridgeport
Gold, L. H., N. Y. Med. '32, Hartford
Goldberg, I. S., Creighton '33, Torrington
Goldberg, S. J., Yale '07, New Haven
Goldberg, S. J., Jr., Harvard '36, New Haven
Goldenberg, J. J., Dalhousie '26, Hartford
Goldman, G., Yale '10, New Haven
Goldmeier, E., Frankfurt '39, Groton
Goldschmidt, M., Med. Coll. of Virginia '38, New Britain
Goldstein, M., Yale '24, New Haven
Goldstein, M. R., Hahnemann '43, Hartford
Goldys, F. M., Tufts '26, Danbury
Golino, E. F., Rochester '36, Hartford
Golomb, E. F., Woman's Med. Pa. '38, Bridgeport
Golston, H., Med. Coll. of Virginia '26, Hartford
Gompertz, M. L., Columbia '37, New Haven
Gonzalez, L. D., Havana '43, Danbury
Good, W. M., Yale '09, Waterbury
Goodell, R. A., Harvard '28, Hartford
Goodrich, W. A., Columbia '35, Hartford
Goodrich, W. J., Albany '39, Bridgeport
Gordon, W. F., Long Island '96, Danbury
Gore, M. A., Maryland '18, Granby, Colo. (Hartford County)
Gorham, G. V., Michigan '30, Norwalk
Gosselin, G. A., Vermont '15, Hartford
Gottesfeld, B. H., Colorado '39, Hartford
Gould, L. N., N. Y. Med. Coll. '27, Hamilton, Ohio (New London County)
Gould, M. M., Tufts '31, Hartford
Gourlie, H. W., Harvard '31, Thompsonville
Grady, J. F., Columbia '32, New Haven
Granniss, I., Yale '96, Old Saybrook
Granoff, M. A., Chieago '37, New Haven
Grant, R. F., Albany '38, Cromwell
Gratz, C. M., Toronto '23, Greenwich
Grau, L. C., Dartmouth '12, Hartford
Gray, A. S., Univ. & Bellevue '15, Hartford
Gray, H. J., St. Louis '21, Hartford
Grayson, M., N. Y. Med. Coll. '41, New London
Green, F. C., Mcharry '41, New Haven
Green, H. H., Johns Hopkins '31, South Norwalk
Green, J. H., Univ. & Bellevue '13, Waterbury
Green, R. H., Johns Hopkins '38, New Haven
Green, W. F., Harvard '32, Newtown
Greenberg, A., Long Island '32, Old Saybrook
Greenblatt, H. J., Vermont '36, New Britain
Greenblatt, J., Louisiana '39, Stamford
Greene, G. S., Harvard '39, Hartford
Greenhouse, B., Yale '21, New Haven
Greenhouse, H. R., N. Y. Med. Coll. '44, New Haven
Greenspun, D. S., Yale '25, Bridgeport
Greiner, G. F., Vanderbilt '40, Kent
Grendon, D. A., Harvard '28, Kent
Grenon, O. A., Georgetown '33, East Haven
Grevatt, K. L., Pennsylvania '35, Redding
Griffin, D. P., Jefferson '14, Bridgeport
Grigas, J. E. Tufts '36, Greenwich
Griggs, J. B., Yale '26, West Hartford
Grillo, V. J., Yale '33, New Haven
Grillo, W., Rochester '38, Waterbury
Grimm, H. W., Jefferson '16, Fairfield
Griswold, A. S., Yale '21, Bridgeport
Griswold, C., Yale '24, Bridgeport
Griswold, E. M., Yale '32, Glastonbury
Griswold, M., Yale '25, New Haven (New London Count
Griswold, M. H., Vermont '13, Hartford
Griswold, M. T., Tufts '05, Harwinton
Groark, J. A., Yale '24, New Haven
Groark, O. J., Med. Chi. Phila. '16, Bridgeport
Grodin, H. W., Yale '17, New Haven
Gross, H. A., N. Y. Med. Coll. '46, Hartford
Grossman, J. H., Rochester '41, Bridgeport
Grossman, W., Berlin '21, Hartford
Grosvenor, F. L., Buffalo '00, Hartford
Grout, S. P., Vermont '04, East Dorset, Vermont (Fairfield County)
Grower, J. H., Nebraska '25, Middletown
Gualtieri, M. V., Tufts '43, Waterbury
Gudernatch, G. S., Cornell '39, Sharon
Guida, F. P., Yale '34, New Haven
Gulash, J. R., Marquette '40, Bridgeport
Gulino, A. J., Tufts '31, Plainfield
Gura, G. M., Loyola '31, Southington
Gurwitz, J., Tufts '38, West Hartford
Gushee, E. S., Harvard '03, Wallingford
Guss, L., Oklahoma '41, Norwich
Guthrie, R. H., Tennessee '21, Norwieh

Haberlin, C. E., Med. Coll. Va., '24 Stratford
Haddad, F. M., Yale '43, Ansonia
Haine, J. W., Albany '43, Stamford
Haines, H. L., Johns Hopkins '39, New London

Hale, F., Columbia '09, Bridgeport
Hale, V. A., Texas '22, Norwich
Haliday, E. G., Queen's '27, Stonington
Hall, L., Harvard '24, Hartford
Hall, M. I., Edinburgh '34, Bristol
Hall, R. W., Yale '07, Bridgeport
Hall, W. C., Pennsylvania '30, Hartford
Hall, W. E., Yale '25, Meriden
Halloran, J. V., Boston '36, Greenwich
Hamilton, J. S. M., McGill '26, Denver, Colo. (Fairfield County)
Hamlin, C. H., Harvard '41, Hartford
Hampton, L. J., Pennsylvania '33, New Haven
Hanaghan, J. A., Harvard '41, Norwich
Hanchett, H. B., Jefferson '05, Torrington
Hankin, M. A., Long Island '33, New Haven
Hanley, J. B., Jefferson '39, Bristol
Hanley, J. L., Jr., Yale '35, Bridgeport
Hanley, J. P., Cornell '06, Stafford Springs
Hanrahan, W. R., P. & S., Balt. '05, Bristol
Hansell, R. J., Ohio '32, Greenwich
Hanson, M. C., Rush '23, Waterbury
Hardenbergh, D. B., Harvard '34, Bridgeport
Harper, P., Yale '31, Baltimore, Md. (Fairfield County)
Harris, B. R., Yale '22, New Haven
Harris, J. S., Yale '32, New Haven
Harris, H. P., Jr., Duke '36, Fairfield
Harris, L. D., Tufts '34, Hartford
Harrison, E. R., Yale '26, New Haven
Harrison, F. M., Jefferson '22, Stamford
Harrison, J. F., Jefferson '03, Stamford
Harshbarger, I. L., Virginia '22, Bridgeport
Hart, B. I., Columbia '04, Bridgeport
Hart, C. J., Hahnemann '03, New Britain
Hart, J. C., Yale '30, New Haven
Hart, J. G., Long Island '41, Westport
Hartman, F. B., Harvard '34, New London
Harty, J. E., Georgetown '37, Waterbury
Harvey, C. C., Cornell '16, Middletown
Harvey, D. F., Yale '33, Hartford
Harvey, E. R., Baltimore '09, Seymour
Harvey, E. R., Jr., Yale '37, Seymour
Harvey, J. LeR., Louisville '14, Waterbury
Harvey, S. C., Yale '11, New Haven
Harvey, S. W., Cornell '46, Middletown
Harvey, T. S., Yale '41, Philadelphia, Penn. (New Haven County)
Harwood, C. W., Vermont '40, Middletown
Hastings, L. P., Vermont '23, Hartford
Hathaway, J. S., Harvard '28, New Haven
Havey, L. A., Vermont '10, Bridgeport
Hawthorne, J., Tulane '20, Greenwich
Haylett, H. B., Vermont '07, East Hartford
Hazen, D. R., Harvard '33, Hartford
Hazen, R., Vermont '98, Thomaston
Heafey, J. R., Syracuse '34, South Norwalk
Hebard, G. W., Cornell '36, New Canaan
Heinemann, M., Goettingen '25, New Haven
Hellijas, C. S., Rochester '41, Hartford
Hendel, I., Jefferson '17, New London
Henderson, A. C., Columbia '03, Stamford
Hendricks, A. L., Yale '07, New Haven
Henkle, R. T., Cornell '31, New London
Hennessey, J. G., Tufts '34, Bridgeport
Hennessy, J. J., Columbia '26, Hartford
Henze, C. W., Yale '00, New Haven
Hepburn, R. H., Harvard '39, Hartford
Hepburn, T. N., Johns Hopkins '05, Hartford
Herman, D. W., Columbia '24, Winsted
Herr, E. A., Vermont '09, Cheshire
Herrick, F. L., Vermont '31, Bennington, Vt. (New Haven County)
Herrmann, A. E., Harvard '23, Waterbury
Hersey, T. F., Tufts '37. New Haven
Hertzberg, R. F., Harvard '26, Stamford
Hervey, Z. P., Vienna '38, East Hartford
Hess, O. W., Buffalo '31, New Haven
Hetzel, J. L., Yale '26, Waterbury
Heublein, G. W., Yale 34, Hartford
Hewes, C. T., Vermont '31, Groton
Heyer, H.H., N. Y. U. '87, New London
Heyman, J., Med. Coll. Va. '17, Hartford
Hiden, R. B., Virginia '23, New Canaan
Hieronymus, E. E., Louisville '33, Louisville, Ky. (New Haven County)
Higgins, H. G., Cornell '33, Milford
Higgins, H. W., Tufts '32, Norwich
Higgins, J. J., Georgetown '28, New Haven
Higgins, W. L., N. Y. U. '90, South Coventry
Hill, E. R., Jefferson '24, Mystic
Hill, E. S., McGill '23, Torrington
Hill, W. E., Bowdoin '21, Naugatuck
Hillier, W. F., Jr., Yale '43, New Haven
Hillman, M. M., Columbia '19, New Haven
Hills, L. H., Wom. Med. Pa. '96, Winter Haven, Fla. (Windham County)
Hinchey, R. J., Tufts '21, Waterbury
Hippolitus, P. D., Yale '12, Bridgeport
Hirata, I., Yale '12, New Haven
Hirschfeld, O. M., Tufts '31, Hartford
Hirshberg, M. S., Tufts '27, Hartford
Hitchins, C. S., Cornell '38, New Haven
Hodgkins, C. H., Hahnemann '36, New Haven
Hodgson, T. C., Toronto '94, Berlin
Hoff, E. C., Oxford '28, Richmond, Va. (New Haven County)
Hoffman, C. C., Buffalo '16, Hartford
Hogan, W. L., Vermont '18, Hartford
Holley, E., Albany '96, Brattleboro, Vt. (Middlesex County)
Hollinshead, J. B., Yale '37, West Hartford
Holt, K. R., Yale '26, Hartford
Holtz, R. S., Vermont '28, Hartford
Hooper, G. H., Boston '29, Bridgeport
Hopper, E. B., Yale '29, Brooklyn, N. Y. (Fairfield County)
Hopper, J. M., Chicago '40, Hartford
Horn, B., N. Y. U. '29, Bridgeport
Horn, M. I., N. Y. Homeo. '15, Bridgeport
Horning, B. G., Harvard '28, Battle Creek, Mich. (Hartford County)
Horowitz, I., Vienna '37 Bridgeport
Horsefield, T. E., Vermont '29, Moodus
Horton, W. H., Boston '40, Hartford
Hough, P. T., McGill '32, Hartford
Houle, R. T., Georgetown '32, East Hartford
Houze, H. G., Queens '24, Westport
Hovenanian, M. S., Boston '40, New Haven
Howard, A. J., Yale '20, New Haven
Howard, H. A., Tufts '29, Wethersfield
Howard, J. H., Georgetown '18, Bridgeport
Howard, L. A., Louisiana '39, Danbury
Howard, M. E., Johns Hopkins '31, New Haven
Howard, W. O., N. Y. U. '32, Tuskegee, Ala. (New Haven County)
Howe, G. E., Harvard '18, Hartford
Howlett, K. S., Vanderbilt '31, Shelton
Hubert, G. R., Yale '35, Torrington
Hudon, F. A., Pennsylvania '37, Bristol

Hughson, D. T., Yale '27, Milwaukee Wisconsin (New Haven County)
Hughson, F. G., Marquette '34, Milwaukee, Wisconsin (New Haven County)
Humpage, N. W., Tufts '36, Torrington
Hunkemeier, E., N. Y. U. '33, South Norwalk
Huntington, F. S., Harvard '24, Darien
Hurlburt, E. G., Vermont '35, Coronado, Calif. (Fairfield County)
Hurwitz, A., Johns Hopkins '33, Newington
Hurwitz, G. H., Maryland '33, Hartford
Huss, J. H., Cornell '42, Meriden
Hutchison, J. E., Johns Hopkins '14, Hartford
Hyde, C. E., Yale '10, Bridgeport
Hymovich, L., Jefferson '29, Stamford
Hynes, F. H., Tufts '13, New Haven

Iannotti, J. P., Naples '38, Plainville
Ignace, S. J., Georgetown '30, Ansonia
Inkster, J. H., Cornell '30, Ridgefield
Intriere, A. D., Michigan '44, Greenwich
Ippolito, T. L., N. Y. Med. Coll. '38, Norwalk
Ireland, R. M., Vermont '31, New Milford (Fairfield County)
Irving, J. G., Toronto '32, Hartford
Irwin, H. H., Tufts '34, New London
Isenman, R., Tufts '30, Westport
Ives, E. B., Tufts '42, Bridgeport

Jack, J. L., Yale '23, New Haven
Jackson, A. F., Howard '22, Hartford
Jackson, A. H., Yale '24, Washington
Jackson, A. J., Columbia '15, Waterbury
Jackson, E. B., Johns Hopkins '21, New Haven
Jacobson, C. E., Jr., Cornell '35, Hartford
Jaffe, S. A., N. Y. U. '38, New Haven
Jaiven, S. J., N. Y. U. '40, Stamford
James, A. G. B., McGill '27, Bridgeport
James, G. R., Yale '10, Hamden
James, L. P., Yale '27, Hartford
James, M. L., Women's Med. Coll. Pa. '07, North Haven
January, D. A., Yale '34, Hartford
January, M. H., Yale '35, Hartford
Janzen, A. H., Kansas '38, New Haven
Jarvis, H. G., Johns Hopkins '10, Hartford
Jenkins, R. H., Med. Coll. Va. '16, New Haven
Jennes, M. L., Tufts '38, Waterbury
Jennes, S. W., Tufts '34, Waterbury
Jennings, W. F., Rush '37, Hartford
Jenovese, J. F., Pennsylvania '30, Hartford
Johnson, A. A., Columbia '17, Waterbury
Johnson, C. E., Harvard '26, New Haven
Johnson, H. A., Vermont '25, Watertown (New Haven County)
Johnson, P., Tufts '32, Hartford
Johnson, W. H. N., Jr., Howard '39, Norwalk
Johnston, E. H., Maryland '00, Waterbury
Johnstone, K. T., Cincinnati, '34, Bridgeport
Jones, E. K., Columbia '34, Bridgeport
Jones, F. S., Yale '28, Hartford
Jordan, R. H., Virginia '33, New Haven
Josephs, W. W., Georgetown '30, New Haven
Joslin, S. L., Yale '43, Fairfield
Joyce, W. M., Jefferson '17, Middletown

Kahn, E., Munich '11, New Haven
Kalett, J., Jefferson '28, New Britain
Kalin, J. I., Harvard '24, Hartford
Kalman, E., Royal Elizabeth U., Hungary '23, Bridgeport
Kane, J. H., Md. Coll. Med. '04, Thomaston
Kaplan, L., Baylor '36, Bridgeport
Kaprielian, H. K., Virginia '08, Old Greenwich
Kardys, J. A., George Washington '30, Hartford
Karlin, F. L., St. Andrews '34, Waterbury
Karotkin, R. H., N. Y. U. '32, Hartford
Karpe, R., Prague '24, Hartford
Karpel, S., Maryland '36, New London
Kartin, B. L., Columbia '39, New Haven
Kaschmann, J., Munich '22, Hartford
Kaschub, R. W., Tufts '35, Groton
Katz, D., Vermont '25, Hartford
Katz, H., Harvard '21, Hartford
Katz, H. W. Tufts '40, New Haven
Katz, I., N. Y. Med. Coll. '37, Meriden
Katz, M. E., Oklahoma '41, Boston, Mass. (New Lond County)
Katzenstein, R. E., Berne '38, Meriden (Middlesex Count
Katzin, B., Johns Hopkins '43, Torrington
Katzman, S. S., Jefferson '21, Hartford
Kaufman, C., Jefferson '19, New London
Kaufman, W., Michigan '38, Bridgeport
Keating, G. A., Long Island '38, Brooklyn, New York (Ne Haven County)
Keating, J. J., N. Y. U. '34, New Milford (Fairfield County
Keddy, R. A., McGill '24, Stamford
Keefe, G. G., Maryland '22, Hartford
Keefe, R. S., Boston '25, Hartford
Keefe, W. J., Maryland '31, Hartford
Keegan, D. F., Maryland '21, Bridgeport
Keeney, R. R., Jr., Tufts '34, Manchester
Keith, A. R., Harvard '03, Annisquam, Mass. (Hartford County)
Kelemen, E., Budapest '25, Greenwich
Kelley, N. R., Harvard '37, Rocky Hill
Kelley, W. O., Johns Hopkins '37, Norwich
Kellogg, H. K. W., Columbia '03, Norwalk
Kelly, C. C., Johns Hopkins '14, Hartford
Kelly, J. C., Queen's '28, Old Greenwich
Kelly, L. C., Cornell '29, Waterbury
Kemp, E. P., Tufts '25, Fairfield
Kendall, R. E., Johns Hopkins '21, Hartford
Kenigsberg, N., Yale '39, Bridgeport
Kennedy, C. S., Georgetown '30, Naugatuck
Kennedy, J. J., Jr., Boston '46, New Haven
Kennedy, R. E., Yale '36, Roanoke, Va. (Fairfield County
Kennedy, W. C., Georgetown '10, New Haven (Litchfield County)
Kenney, W. E., Yale '41, Hartford
Kertesz, J., Vienna '24, New Haven
Kessler, F., Vienna '37, West Haven
Kettle, R. H., Queen's '28, Norwich
Keys, R. C., Kansas '27, South Norwalk
Kezel, A. P. C., Georgetown '35, Stamford
Kidney, J. J., Jefferson '43, Clinton
Kilbourn, A., Yale '23, Hartford
Kilbourn, J. B., P. & S., Balt. '11, Hartford
Kilgus, J. F., Maryland '31, Litchfield
Kinder, F. S., Cornell '38, Bridgeport
Kingman, J. H., Columbia '85, New Haven (Middlese County)
Kingsbury, I. W., Columbia '03, Perry, Maine (Hartfor County)
Kinney, K. K., Iowa '21, Willimantic
Kirby, S. B., Yale '28, New Haven
Kirsch, N., Long Island '40, Hartford
Kirschbaum, E. H., Yale '12, Waterbury
Klatskin, G., Cornell '33, New Haven
Klebanoff, H. E., Yale '25, New Haven
Klein, A. A., Louisville '29, Hartford

lein, H. T., Illinois '40, Stamford
lein, J., Long Island '34, Hartford
lein, R. H., Women's Med. Coll. Pa. '40, West Hartford
leiner, S. B., Yale '15, New Haven
leinman, H. L., Buffalo '41, Bridgeport
lumpp, T. G., Harvard '28, New York City (New Haven County)
napp, C. S., Columbia '19, Greenwich
napp, C. W., Columbia '12, Newtown
napp, R. P., Columbia '11, Manchester
nauth, M. S., Columbia '23, Wilton
neale, H. B., Johns Hopkins '20, Bridgeport
nepp, J. W., Richmond '05, Hartford (Fairfield County)
night, H. C., Tulane '33, Middletown
offler, A., Jefferson '34, Stamford
ogut, H. V., N. Y. Med. Coll. '43, Bridgeport
oleshko, L. J., Maryland '42, Waterbury
onopka, F. J., Georgetown '31, Wallingford
ornblut, A., N. Y. U. '20, Bridgeport
oster, L. W., N. Y. U. '37, West Haven
ott, J. H., N. Y. U. '33, Torrington
oufman, W. B., Tufts '35, New Haven
rall, I. H., Long Island '37, Hartford
raszewski, H. W., Tufts '38, New Britain
rinsky, C. M., Tufts '33, New London
rochmal, H., Vienna '37, Meriden
rosnick, G., Jefferson '38, Boston, Mass. (New Haven County)
rosnick, M. Y., Yale '30, New Haven
ucewicz, W. J., St. Louis '36, Richmond, Va. (Hartford County)
unkel, F. E., Yale '26, Hartford
unkel, P., St. Louis '34, Newington
ushlan, S. D., Yale '35, New Haven
yle, G. B., Long Island '38, Sandy Hook

aakso, A. O., Cornell '37, Danielson
a Bella, L. O., Columbia '25, Middletown
abensky, A., Yale '21, New London
aBrecque, F. C., Tufts '35, Waterbury
abuz, E. F., Tufts '37, Bristol
acava, J. J., Georgetown '34, New Britain
ach, F. E., Maryland '41, New Haven
ambert, H. B., Jefferson '09, Rocky Hill (Fairfield County)
aMoure, C. TenE., Albany '94, Windham Center (Tolland County)
amoureux, E. E., Tufts '35, Hartford
ampson, E. R., Columbia '96, Hartford
ampson, R. S., Harvard '34, Hartford
andecker, N., Friedrich Wilhelm '26, Bridgeport
andry, A. B., Jefferson '09, Hartford
andry, B. B., Harvard '20, Hartford
ane, W. Z., Columbia '42, Darien
ang, W. P., Hahnemann '01, North Haven
angner, H. P., Yale '22, Milford
ankin, J. J., Harvard '37, Hartford
apenta, R. G., George Washington '37, Hartford
aPierre, A. R., Columbia '38, Norwich
aPlume, A. A., Montreal '24, Bristol
arimore, L. D., Wom. Med. Coll. Pa. '15, Greenwich
arkin, C. L., Yale '15, Waterbury
arrabee, J. W., Harvard '26, Hartford
arson, A. L., Albany '35, Hartford
aszlo, A., Kiel '23, Bridgeport
aTaif, C. G., Hahnemann '36, New Milford
atimer, M. L., Vanderbilt '32, New Haven
aube, P. J., Iowa '36, Tsinan-Shantung China (New Haven County)
Lavietes, P. H., Yale '30, New Haven
Lawton, R. J., Md. Coll. Med. '08, Terryville
Leak, R. L., Albany '98, West Hartford
Lear, M., Yale '11, New Haven
Leary, D. C., Yale '36, Hamden, Conn. (Windham County)
Lebhar, N. F., Columbia '39, Westport
Lechausse, R. M., Med. Coll. of Va. '35, Manchester
Leddy, P. A., Harvard '24, Portland, Me. (New Haven County)
Lee, F. N., Kansas '23, Milford
Lee, J. R., Queen's '24, Devon
Lehndorff, P. G., Vienna '37, Boston, Mass. (Windham County)
Lena, H. F., Johns Hopkins '16, New London
Lencz, E., Vienna '36, Derby
Lenehan, J. R., Jefferson '37, Hartford
Lengyel, P., Budapest '31, Bridgeport
Lenkowski, W. J., N. Y. U. '37, Waterbury
Lennox, M. A., Yale '39, New Haven
Lenoci, R. J., Hahnemann '40, Bridgeport
Leonard, G. A., Md. Coll. Med. '05, New Orleans, La. (New Haven County)
Leonard, J. C., Yale '32, Hartford
Leonard, M., Yale '31, New Haven
Leonard, R. J., Georgetown '38, New Haven (Tolland County)
Leong, E. F., Rush '26, Stamford
Lesko, J. M., Duke '38, Bridgeport
Levenson, A., Tufts '22, Bridgeport
Leverty, C. J., Univ. & Bellevue '01, Bridgeport
Levin, A. E., Tufts '30, Hartford
Levin, H. A., Univ. & Bellevue '18, New Haven
Levin, R. R., Harvard '36, Hartford
Levine, A. I., New York Univ. '35, Cos Cob
Levine, H., Harvard '41, New Britain
Levine, L. W., Maryland '37, Ellington
Levine, S. S., P. & S., Balt. '12, Hartford
Levinsky, A., Alabama '20, Bridgeport
Levinsky, M., Maryland '28, Bridgeport
Levy, A., Tufts '31, Winsted
Levy, D. F., Yale '19, New Haven
Levy, M. N., Tufts '23, Bridgeport
Levy, N., Yale '27, Branford
Levy, S. H., Tufts '35, Stratford
Levy, W., Yale '11, Suffield
Lewicki, E. S., Georgetown '35, Waterbury
Lewis, D. M., Johns Hopkins '01, New Haven
Lewis, H. D., Harvard '42, New Haven
Lewis, R. M., Pennsylvania '10, New Haven
Lewis, S. D., George Washington '31, Hartford
L'Heureux, J. A., Boston '34, Meriden
Lieberman, D. L., N. Y. U. '26, Middletown
Lieberthal, M. M., N. Y. U. '35, Bridgeport
Liebow, A. A., Yale '35, New Haven
Linde, J. I., Yale '08, New Haven
Linder, J. H., Columbia '27, Sharon
Lindsay, M. S., Tufts '11, Middletown
Lindsey, D., Yale '43, Guilford
Lindskog, G. E., Harvard '28, New Haven
Lipkoff, C. J., N. Y. U. '36, Milford
Lipton, H., St. Louis '32, Danbury
Lirot, S. L. R., McGill '32, Meriden
Lischner, M. D., Yale '30, Hartford
Litter, L., Basel '36, Hartford
Little, H. C., Yale '10, New Haven
Little, M. F., Yale '28, Hartford
Little, M. H., Harvard '35, Willimantic
Little, O. A. G., Boston '35, Willimantic

Littwin, R. J., Long Island '36, Bristol
Lobb, R. A., Hahnemann '37, Deep River
Locke, H. L. F., Tufts '12, Hartford
Lockhart, R. H., Yale '28, Bridgeport
Lockwood, H. DeF., Yale '01, Meriden
Lockwood, J., Johns Hopkins '30, Greenwich
Loffredo, L., Pennsylvania '22, Middletown
Logan, W. J., Yale '25, New Haven
Lohrmann, W., Rochester '43, Meriden
Loiacono, A. J., Harvard '27, New London
Loiacono, R. A., N. Y. Med. Coll. '43, New London
Lolli, G., Rome '28, New Haven
Lombardi, P. F., Tufts '21, Waterbury
Longo, A. D., Georgetown '38, Portland
Lopatin, C., Louisville '41, Bridgeport
LoRusso, D. L., Marquette '34, Torrington
Louderbough, H., Vermont '38, Watertown
Lovelace, T. R., Howard '30, Waterbury
Loveland, E. K., Yale '97, Watertown
LoVetere, A. A., George Washington '35, New Britain
Lowell, W. H., Jr., Harvard '37, Hartford
Lowman, R. M., Maryland '36, New Haven
Lubchansky, J. H., N. Y. U. '33, Uncasville
Lublin, R. D., Johns Hopkins '29, East Hartford
Luby, T. J., McGill '14, Hartford
Luckner, W. G., Jefferson '38, Stafford Springs
Ludlow, G. C., Harvard '19, New Canaan
Lukoski, W. A., Georgetown '32, Waterford
Lundberg, G. A. F., Jefferson, '19, South Manchester
Lundborg, F. L., Yale '30, West Hartford
Lutz, W. G., Munich '36, New York City (New Haven County)
Lydon, L. G. M., Yale '40, New Haven
Lyddy, J. R.. N. Y. U. '44, Bridgeport
Lyman, D. R., Virginia '99, Wallingford
Lynch, E. J., Pennsylvania '09, Shelton
Lynch, H., N. Y. U. '24, Bridgeport
Lynch, J. C., N. Y. U. '86, Bridgeport
Lynch, R. J., Bellevue '97, Bridgeport
Lynch, V. A., Jefferson '38, Bridgeport
Lyon, G. A., Cornell '41, Bridgeport
Lyon, H. P., McGill '36, Hartell, Liberia, West Africa (Hartford County)

MacCready, P. B., Johns Hopkins '21, New Haven
MacCready, W. H., Harvard '27, Windsor
MacDougall, A. D., Cornell '43, Groton
Mackay, W. D., Indiana '28, Sharon
MacKee, G. M., New York Med. Coll. '99, Stamford
MacLean, E. M., McGill '30, Farmington
MacLeod, E. A., Wom. Med. Coll. Pa. '25, Niantic
MacNish, J. F., Yale '17, New Haven
MacQuigg, D. E., Ohio '43, El Paso Texas (New Haven County)
Madden, L. I., Harvard '10, Hartford
Magnano, J., Yale '27, Middletown
Maher, J. R., Boston '27, Stratford
Mahoney, D. F. C., Georgetown '24, Redlands, Calif. (Hartford County)
Mahoney, J. J., McGill '33, Norwich
Mainer, R. G., Vermont '39, New York City (Hartford County)
Maislen, S., Vermont '14, Hartford
Malloy, E. F., Cornell '28, Stamford
Malone, R. F., Tufts '43, Milford
Mancinelli, M. J., Hahnemann '43, Stamford
Mancoll, M. M., Jefferson '28, Hartford
Mandl, G., Vienna '32, Bethel
Manganiello, L. O. J., Maryland '42, Waterbury
Manwaring, I. J., Pennsylvania '95, Norwich
Marglis, B., Bowdoin '20, Bridgeport
Margold, A. M., Vermont '25, South Norwalk
Margolick, M., McGill '35, Putnam
Margolius, N., Cornell '33, Waterbury
Marinaro, N. A., St. Louis '30, Hartford
Marinoff, P. A., Rome '41, Milford
Markle, R. D., Syracuse '37, Waterbury (Litchfield Cou
Markoff, A., Long Island '32, New Haven
Markoff, K. K., Vermont '19, Norwich
Markwald, H. W., Berlin '37, New Hartford
Marranzini, S., N. Y. U. '28, Hartford
Marsh, A. D., Yale '08, Hampton
Marsh, F., Bologna '37, Manchester
Marshak, I. J., Tufts '26, New Haven
Marshall, C. L., Howard '24, New Haven
Martin, J. E., Dalhousie '42, Norwich
Martin, J. G., Yale '33, West Hartford
Martin, J. S., Yale '05, Watertown
Martin, R. A., Vermont '37, Bridgeport
Martin, S. J., Wisconsin '35, Hartford
Marvin, H. M., Harvard '18, New Haven
Maslak, R., Louisville '34, Warehouse Point
Massa, A. F., Yale '18, New Haven
Massaro, J., Yale '45, Manchester
Massey, D. M., Hahnemann '36, Bridgeport
Mastrangelo, A., Jr., Boston '39, Stamford
Mastroianni, L., Padua '17, New Haven
Mastronarde, N. A., Yale '32, Hartford
Mathews, F. P., Harvard '30, New Haven
Matteis, J. T., Yale '26, New Britain
Maurer, L. L., Yale '16, New Haven
Maurer, W. S., Yale '38, Willimantic
Maxwell, J. A., Med. Coll. Va. '17, Bridgeport
Mayo, E. R., Tufts '38, Waterbury
McAlenney, P. F., Yale '29, New Haven
McCabe, E. J., Yale '26, New York City (New Haven County)
McClellan, W. E., Toronto '04, Hartford
McCombs, A. P., Cornell '29, Wilton
McCormack, C. J., Yale '29, Hartford
McCrann, D. J., Tufts '34, Hartford
McCue, M. P., Harvard '34, East Hartford
McDermott, J. F., Cornell '23, Hartford
McFarland, F. W., Vermont '28, Stamford
McGaughey, J. D., Jefferson '10, Wallingford
McGaughey, J. D., III, Jefferson '44, Wallingford
McGourty, A. F., N. Y. Homeo. '18, Stamford
McGourty, D. P., Jefferson '27, Stamford
McGovern, E. F., Univ. & Bellevue '01, Bridgeport
McGrath, J. F., McGill '23, Hartford
McGrath, J. H., Yale '08, Waterbury
McGuire, F. J., Boston '37, Guilford
McGuire, W. C., Yale '09, New Haven
McIlroy, P. T., Queens '16, Danbury
McKeon, J. J., Hahnemann '39, Hamden
McLarney, T. J., P. & S., Balt. '97, Hartford (New Ha County)
McLaughlin, J. H., P. & S., Balt. '09, Jewett City
McLean, J. J., Tufts '20, Hartford
McLean, T. S., Jr., Vermont '34, Bridgeport
McLellan, P. G., Harvard '25, Hartford
McLeod, C. E., Vermont '34, Middletown
McMahon, F. C., Fordham '19, Stamford
McMahon, G. W., Tufts '37, New Britain
McMahon, J. D., Creighton '37, South Norwalk
McMahon, W. H., Jr., Fordham '20, South Norwalk
McNamara, A. P., George Washington '41, Bridgeport
McNulty, T. F., Georgetown '32, Hartford

McPartland, C. E., Johns Hopkins '23, West Hartford
McQueen, A. S., Yale '01, Branford
McQueeney, A. M., Yale '05, Bridgeport
Meacham, C. T., Pennsylvania '30, Stamford
Meeker, D. O., Rochester '29, Riverside
Meigs, J. W., Harvard '40, New Haven
Mekrut, J. A., St. Louis '31, Meriden
Mellion, J., Yale '23, New Britain
Mendelsohn, W., Johns Hopkins '33, New Haven
Mendillo, A. J., Yale '07, New Haven
Mendillo, J. C. F., Yale '30, New Haven
Menousek, J. A., Vermont '32, Plainville
Meo, R. C., George Washington '34, Waterbury
Merrill, W. T., Dartmouth '90, East Milton, Mass. (New Haven County)
Merriman, H., Columbia '36, Waterbury
Merriman, M. H., Columbia '06, Waterbury
Merwin, T. K., N. Y. Med. Col. '40, Hartford
Meschter, E. F., Med. Chi. Phila. '98, Stamford
Meshken, J., Rush '37, Bridgeport
Messina, M. C., Tennessee '27, Hartford
Metcalf, E. H., Jefferson '14, Rockville
Meyer, F. M., Indiana '28, Bridgeport
Meyers, R. A., Michigan '31, Watertown
Mezey, C. M., Royal U. Budapest '18, Great Falls, Montana (New London County)
Michael, S. T., Prague '37, New Haven
Michalowski, V. S., Boston '29, New Britain
Middlebrook, L. F., Jr., Johns Hopkins '30, Hartford
Mignone, J., Yale '33, New Haven
Milano, N. A., Georgetown '27, West Haven
Miles, H. S., Columbia '91, Bridgeport
Milici, J. J., Hahnemann '40, New Haven
Millen, S. R., George Washington '38, New Haven
Miller, G. R., Tufts '39, Manchester
Miller, H. B., Rush '33, Hartford
Miller, H. K., Columbia '32, Stamford
Miller, J.. Cornell '15, Greenwich
Miller, J. R., Johns Hopkins '11, Hartford
Miller, S. M., Tulane '41, Hartford
Mills, B. L., Vermont '25, Meriden
Mills, C. W., Cornell '38, Norwalk
Minor, L. W., Yale '32, Middletown
Mirabile, C. S., McGill '30, Hartford
Mirabile, T. J., Georgetown '37, East Hartford
Missett, J. S., Columbia '40, West Hartford
Misuk, J. F., Georgetown '32, Meriden
Mitchell, G. V., McGill '38, Torrington
Mlynarski, J. A., Georgetown '39, New Britain
Mogil, M., Buffalo '39, New Haven
Moher, J. J., Yale '37, Hartford
Moise, T. S., Johns Hopkins '17, Washington, D. C. (Hartford County)
Molnar, G. J., Georgetown '43, Bridgeport
Monacella, J. M., Columbia '35, Windsor
Monagan, T. M., Harvard '40, Waterbury
Monahan, D. T., Yale '33, Bridgeport
Mongillo, F., Med. Coll. Va. '28, New Haven
Montano, C. C., Tufts '35, Hartford
Mooney, S., Tufts '27, Bridgeport
Moorad, P. J., Rochester '31, New Britain
Moore, B. E., Harvard '37, New Haven
Moore, C. D., Queen's '28, Stamford
Moore, D. B., Tufts '35, New Haven
Moore, G. E., Yale '34, Darien
Moore, H. F., Missouri '98, Bethel
Moore, M. R., Queen's '29, Norwich
Moore, W. J., Columbia '21, Cheshire
Morgan, K. R., Yale '42, New Haven
Morgan, W. O., Georgetown '30, Westport
Moriarty, M. E., Yale '26, South Manchester
Morrill, H. F., Harvard '25, Waterbury
Morris, F. R., Maryland '41, Bridgeport
Morris, J. S., Texas '27, Greenwich
Morrison, D. R., Cornell '39, West Hartford
Morriss, W. H., Johns Hopkins '12, Wallingford
Morrissett, L. E., Med. Coll. Va.. '36, Greenwich
Morrissey, M. J., P. & S., Balt. '97, Hartford
Morse, A. H., Johns Hopkins '06, New Haven
Morse, L. R., Queen's '26, Hartford
Morse, W. J., Vermont '31, New London
Moser, O. A., Yale '02, Rocky Hill
Moss, H. G., N. Y. U. '28, New Haven
Mott, F. E., Buffalo '41, New Haven
Mouradian, M. G., Wom. Med. Coll. Pa. '13, New Britain
Moxness, B. A., Georgetown '25, U. S. Army (Hartford County)
Moxon, G. F., Marquette '30, Mansfield Depot (Windham County)
Moylan, T. P., Buffalo '22, Hartford
Moyle, H. B., Toronto '10, Hartford
Mozzer, A. J., Hahnemann '38, Manchester
Mucci, L. A., Rochester '34, Greenville, Mississippi (Hartford County)
Mulaire, V. J., Boston '39, Stamford
Mullaney, T. P., Jr., Vermont '46, Windsor Locks
Mullen, J. J., Tufts '29, Waterbury
Mulligan, M., Boston '38, Waterbury
Mullins, S. F., Univ. & Bellevue '06, Danbury
Mulville, M. F., Tufts '37, Hartford
Murcko, W. J., Marquette '37, Torrington
Murdock, T. P., Maryland '10, Meriden
Murphy, C. A., Long Island '33, Stamford
Murphy, J., Pennsylvania '95, Middletown
Murphy, J. J., Georgetown '35, Danbury
Murphy, J. J., Tufts '43, East Hartford
Murphy, O. L., Vermont '21, Simsbury
Murphy, T. B., Harvard '23, Wallingford
Murphy, T. D., Columbia '30, Simsbury
Murphy, T. F., Jefferson '33, West Hartford
Murray, H. J., Jefferson '16, Stamford
Murray, T. J., Maryland '10, New London
Murray, T. O., Tufts '32, Danbury
Murray, W. J., Jefferson '32, Bridgeport
Musselman, L. K., Johns Hopkins '19, New Haven
Mylon, E., Berlin '20, New Haven

Nagle, W. T., Med. Chi. Phila. '14, Southington
Nagourney, D., Long Island '36, Bridgeport
Nahum, L. H., Yale '16, New Haven
Narowski, J. J., Tufts '43, Derby
Naylor, J. H., Vermont '95, Hartford
Neff, W. E., Jr., Columbia '33, Cheshire
Neidlinger, W. J., Cornell '33, Hartford
Nelson, W. N., George Washington '26, Cromwell
Nemoitin, B. O., Long Island '34, Stamford
Nemoitin, J., Columbia '05, Stamford
Nesbit, R. R., Albany '29, New Haven
Nespeco, J. V., Georgetown '32, Bridgeport
Nespor, R. W., Boston '33, Westport
Nestos, P. A., Rush '14, Bristol
Nettleton, I. LaF., Long Island '98, Bridgeport
Neumann, H. A., Long Island '09, Bridgeport
Neuswanger, C. H., Harvard '23, Waterbury
Nevulis, A. V., Vermont '38, New Britain
Newman, A. A., Long Island '42, Bridgeport
Newman, H. R., Toronto '35, New Haven
Newman, J. T., Yale '19, New Haven

Newman, R., Johns Hopkins '30, New Haven
Newton, L., N. Y. Homeo. '31, Bridgeport
Nichols, C. W., Vermont '20, Bridgeport
Nichols, E., Yale '39, Hartford
Nichols, F. L., Columbia '42, Hartford
Nichols, R. W., Johns Hopkins '12, New Haven
Nickum, J. S., Tufts '18, Bridgeport
Nielsen, T. M., Copenhagen '38, New London
Noble, R. P., Columbia '40, Sharon
Nodelman, J., Yale '29, New Haven
Nolan, J. F., McGill '32, Bridgeport
Nolan, J. O'L., Tufts '40, Hartford
Northman, F. F., Breslau '34, Bridgeport
Northrop, R. A., Jefferson '32, Norwalk

Oberg, F. T., Harvard '16, Bridgeport
O'Brasky, G. H., Jefferson '20, New Haven
O'Brasky, L., Jefferson '22, New Haven
O'Brien, H. R., Michigan '19, Washington, D. C. (Hartford County)
O'Brien, J. F., Yale '08, Waterford
O'Brien, W. H. J., Yale '12, New Haven
O'Connell, E. J., Tufts '34, Unionville
O'Connell, J. D., Harvard '39, Hartford
O'Connell, J. F., Vermont '21, Hartford
O'Connell, M. F., Yale '22, Hartford
O'Connell, P. H., Loyola '29, Norwich
O'Connell, W. M., Yale '17, West Haven
O'Connor, D. S., Bowdoin '19, New Haven
O'Donnell, T. J., Syracuse '08, Greenwich
Oelschlegel, H. C., Jefferson, '11, Torrington
Oesau, H. T., Jefferson '26, Stratford
O'Flaherty, E. P., Cornell '01, Hartford
Ogden, F. N., Columbia '42, Norwalk
Ogden, R. T., Harvard '24, Hartford
Ogilvie, J. B., Yale '34, Stamford
Ohman, R. J., Tufts '41, Waterbury
Olmsted, J. G. M., McGill '25, Hartford
O'Looney, J. J., Jr., Jefferson '45, Bridgeport
Olore, L., Tufts '43, Waterbury
O'Loughlin, T. F., N. Y. U. '96, Rockville
Oltman, J. E., Minnesota '34, Newtown
O'Meara, F. P., N. Y. Med. Coll. '36, Stamford
Onderdonk, H. J., Univ. & Bellevue '97, East Hartford
O'Neil, M. L., Yale '29, Jewett City
O'Neil, V. D., McGill '41, Newington
O'Neill, C. W., Yale '26, Hartford
O'Neill, J. J., Tufts '32, Bridgeport
Oppenheimer, K., Heidelberg '20, Norwich
Opper, L., Munich '33, Torrington
Orbach, E. J., Friedrich Wilhelm Univ., Berlin '24, New Britain
Orlowski, A. W., Tufts '36, Torrington
Oros, L. M., Budapest '37, Bridgeport
Osborn, S. H., Tufts '14, Hartford
Osgood, C., Columbia '03, Norwich
Osmond, R. H., Yale '23, Hartford
Oster, K. A., Cologne '34, Bridgeport
Otis, F. N., Tufts '18, Meriden
Otis, I. S., George Washington '17, Meriden
Ottenheimer, E. J., Virginia '22, Willimantic
Oughterson, A. W., Harvard '29, New Haven
Owen, P. S., Yale 37, Washington, D. C. (Middlesex County)
Owens, A. P., McGill '37, Bridgeport
Oxnard, E. W., Harvard '36, Cheshire

Padula, R. D., Cincinnati '30, Norwalk
Padula, V. D., Rome '35, Hartford
Pagliaro, J. J., Georgetown '37, Shelton
Paladino, J. S., Boston '26, Hartford
Paley, I. M., Long Island '36, Stamford
Palmieri, M. L., Yale '32, Middletown
Palmieri, M. W., Naples '33, New Haven
Panettieri, A. J., Vermont '37, Bridgeport
Paolillo, C. G., Yale '35, New Britain
Papa, J. S., Tufts '28, Bristol
Pappenheim, E., Vienna '35, Springdale
Parente, L., Emory '31, Hamden
Paris, M., N. Y. U. '30, South Norwalk
Park, P. A., Iowa Homeo. '10, Bristol
Parker, J. W., Yale '06, Hartford
Parker, R. L., Western Ontario '41, Bridgeport
Parlato, H. A., N. Y. U. '36, New Britain
Parlato, M. A., Yale '08, Derby
Parmelee, B. M., Vermont '19, Bridgeport
Parrella, G. S., Yale '41, New Haven
Parrella, L. A., Tufts '34, North Haven
Parshley, P. F., Pennsylvania '27, West Hartford
Partridge, W. P., Harvard '20, Hartford
Pascal, T. J., Rush '31, Bridgeport
Pasetto, E., Vermont '36, Waterbury
Pasquariello, D. W., Naples '36, Bridgeport
Pasternak, M., Toronto '36, New Haven
Patterson, F. A., Harvard '27, Norwalk
Paul, F., Munich '24, Norwalk
Paul, J. R., Johns Hopkins '19, New Haven
Paul, V. A., Hahnemann, Chicago '13, Stamford
Peacock, A. U., Rush, '33, Hartford
Pearce, M. G., Texas '22, New Canaan
Pease, M. C., Columbia '06, Ridgefield
Peck, B. C., Long Island '31, New Britain
Peck, R. E., Yale '93, Concord, New Hampshire (New Haven County)
Peckham C. H., Johns Hopkins '23, Manchester
Pellens, M., Cornell '30, Bridgeport
Pelliccia, O., Jr., Johns Hopkins '39, New Haven
Pelz, K., Vienna '32, Wallingford
Pendleton, C. E., Yale '03, Colchester
Pendleton, E. R., P. & S., Boston '04, Westfield, Mass. (Hartford County)
Penner, S. L., Columbia '34, Stratford
Pennington, H. F., Harvard '27, Meriden
Pepe, A. J., Maryland '35, Norwich
Perakos, G. P., Georgetown '32, New Britain
Perham, W. S., Michigan '32, New Haven
Perkins, C. W., Hahnemann '01, Norwalk
Perkins, J. A., McGill '41, Montreal, Canada (Hartford County)
Perreault, J. N., Tufts '07, Danielson
Perrins, H. B., Yale '18, New Haven
Perry, M. J., Wom. Med. Homeo. N. Y. '03, Norwalk
Peters, J. P., Columbia '13, New Haven
Peterson, C. K., Tufts '05, Lakeville
Peterson, E. B., Vermont '28, Norwich
Petrelli, J., Yale '25, New Haven
Petrillo, C., Yale '38, New Haven
Pharris, C., Tennessee '29, Glastonbury
Phelps, M. O., McGill '29, Hartford
Phelps, P. S., McGill '30, Hartford
Philipson, S., N. Y. Homeo. '18, New Haven
Phillips, F. L., Yale '06, New Haven
Phillips, H. S., Toronto '22, Westport
Phillips, K. T., Tufts '19, Putnam
Phillips, N. T., Boston '44, Norwich
Piasecki, J. L., Maryland '12, Norwalk
Piasta, P. F., Boston '24, Middletown
Piazza, G. J., Boston '32, New Haven
Piccolo, P. A., Maryland '37, New Haven

Pierce, H. F., Johns Hopkins '35, Rocky Hill
Pierson, E. M., Yale '24, Cromwell
Pierson, L. A., Tufts '27, Meriden
Pike, E. R., Michigan '98, East Woodstock
Pike, M. M., Harvard '25, Hartford
Pilecki, P. J., Loyola '43, Middletown
Pileggi, P., Maryland '28, Bridgeport
Pinn, A. S., Laval '29, New Haven
Pitegoff, C. H., St. Louis '40, New Haven
Pitegoff, G. I., St. Louis '37, Hartford
Pitock, M. P., Tufts '30, Bridgeport
Pizzi, P. J., Marquette '40, Manchester
Plachta, A., Warsaw '30, New York City (Hartford County)
Platt, J. W., Columbia '40, Mystic
Platt, I. S., Southern California '12, Waterbury
Platt, W. L., Columbia '81, Newtown (Litchfield County)
Plukas, J. M., Georgetown '32, Bridgeport
Poczabut, J. S., Vermont '41, Stamford
Poirier, T. M., Georgetown '34, Windsor
Pola, W. E., Louisville '32, New Britain
Polito, F. L., Yale '21, Torrington
Pollard, R. L., Tufts '36, Waterbury
Pomeroy, N. A., Columbia '96, Waterbury
Pomeroy, W. H., Maryland '43, Poquonock
Poole, A. K., Johns Hopkins '23, New Haven
Popkin, M. S., George Washington '35, Bridgeport
Post, E. A., Georgetown '33, Waterbury
Poverman, D., Vermont '32, New Haven
Powell, W., Queen's '24, New Haven
Powers, G. F., Johns Hopkins '13, New Haven
Pratt, A. M., Univ. & Bellevue '92, Deep River
Pratt, A. P., Harvard '22, Windsor
Pratt, G. K., Detroit '15, Bridgeport
Pratt, N. T., Yale '04, Old Saybrook (Fairfield County)
Preston, T. R., Yale '25, West Hartford
Priddy, F. E., Northwestern '28, Hartford
Prignano, J. V., Georgetown '40, Manchester
Prosser, F. D., Cornell '28, Putnam
Prout, E. B., Syracuse '14, Portland
Pullen, R. W., Yale '21, New Britain
Purinton, C. O., Yale '00, New Hartford (Hartford County)
Purney, J., Jr., McGill '39, West Hartford
Pyle, E., Columbia '15, Waterbury

Quarrier, S. S., Columbia '32, Hartford
Quatrano, J. C., Vermont '31, Bridgeport
Quinlan, R. V., P. & S., Balt. '10, Meriden
Quinn, J. F., P .& S., Balt. '06, Bridgeport
Quinn, K. S., Temple '35, Bridgeport
Quinn, R. J., P. & S., Balt. '13, Waterbury
Quintiliani, A., Harvard '29, Norwich

Rabinovitch, A., Vermont '19, Norwich
Rademacher, E. S., Iowa '23, New Haven
Radin, M. J., Columbia '16, Hartford
Radom, M. M., Jefferson '25, Hartford
Raffa, J., Columbia '34, Glastonbury
Raffaele, F. J., W. Ontario '30, Old Greenwich
Rafferty, B., Jefferson '28, Willimantic
Rafkind, A. B., Paris '37, Middletown
Rand, R. F., Johns Hopkins '00, New Haven
Randall, W. S., Columbia '86, Shelton
Rankin, B. F., McGill '19, Hartford
Rankin, E. C., Nebraska '43, West Hartford
Rapp, A. G., Cornell '29, New London
Rasmussen, H. N., Tufts '25, Uncasville
Rawls, E. C., Med. Coll. Va. '31, Stamford
Raymer, J. G., Harvard '25, Norwich
Read, F. A., Yale '34, Old Greenwich
Reade, E. G., Jefferson '16, Watertown
Reardon, W. F., P. & S., Balt. '04, Hartford
Redlich, F. C., Vienna '35, New Haven
Reich, U. S., Virginia '09, Bridgeport
Reichenbach, A. E., Tufts '38, Waterbury
Reidy, D. D., Columbia '27, Hartford
Reilly, W. J., Tufts '35, Naugatuck
Reiter, B. R., Harvard '34, Bridgeport
Renehan, J. M., Tufts '28, Ansonia
Rentsch, S. B., Michigan '23, Derby
Resnik, E., McGill '30, New Britain
Resnik, H., Johns Hopkins '31, Bridgeport
Resnik, W. H., Johns Hopkins '21, Stamford
Resnisky, A. F., Georgetown '23, Hartford
Reynolds, H. St. C., Yale '10, Hartford
Reynolds, H. S., Albany '14, Hartford
Reynolds, J. A., Tufts '36, Waterbury
Reynolds, W. M., Columbia '31, Greenwich
Ribner, H., Tufts '34, Bridgeport
Ricca, R. A., Pennsylvania '40, Glastonbury
Riccio, J. S., St. Louis '37, New Haven
Riccitelli, M. L., Yale '22, New Haven
Richards, W. R., Cornell '35, New Haven
Richardson, R. A., Vermont '14, Bristol
Riendeau, F. M., Paris '27, Torrington
Riendeau, P. L., Paris '27, Torrington
Riesmann, J. P., Pennsylvania '38, New Haven
Rilance, A. B., McGill '31, New Haven
Rindge, M. E., Duke '41, Madison
Rindge, M. P., P. & S., Cleveland '05, Madison
Rindge, N. P., Yale '35, Clinton
Riordan, M. D., Vermont '12, Willimantic
Robb, S. A., Cornell '40, Meriden
Roberge, G. E., Yale '38, Stratford
Roberts, D. J., Vermont '16, Hartford
Roberts, E. R., Maine '13, Bridgeport
Roberts, F. W., Johns Hopkins '24, New Haven
Robey, N. C., Yale '17, Toledo Ohio (Fairfield County)
Robinson, A. J., Toronto '23, Hartford
Robinson, W. J. T., Long Island '21, Broad Brook
Robison, R. C., Yale '36, Stamford
Roccapriore, B. A., Jefferson '31, Middletown
Rocco, M. P., Georgetown '41, Hartford
Roch, G. E., Tufts '34, Hartford (Windham County)
Roche, A. F., Georgetown '17, Hartford
Roche, T. J., P. & S. Balt. '11, Bridgeport
Rockwell, A. E., Johns Hopkins '21, Bridgeport
Rogawski, A. S., Vienna '38, Beverly Hills, California (New Haven County)
Rogers, F. P., Syracuse '33, West Hartford
Rogers, O. F., Jr., Harvard '12, New Haven
Rogers, P. H., Yale '12, West Haven
Rogers, R. P., Harvard '25, Greenwich
Rogol, L., Long Island '33, Danbury
Rogol, O., Dalhousie '32, Seymour
Rogowski, B. A., Yale '24, New Haven
Rollins, H. B., Yale '22, Hartford
Romaniello, R. J., Columbia '27, Elmwood
Rooney, J. F., P. & S., Balt. '03, Hartford
Root, J. H., Harvard '18, Waterbury
Root, J. H., Jr., Syracuse '43, Waterbury
Root, M. T., Cornell '18, West Hartford
Root, S. A., Cornell '19, West Hartford
Rosahn, P. D., N. Y. U. '28, New Britain
Rose, S. A., N. Y. U. '23, Stamford
Rosen, T., Tufts '33, Manchester
Rosenbaum, G. J., Tufts '34, Hartford
Rosenberg, H. A., Vienna '37, Bridgeport

Rosenberg, H. A., Yale '30, Waterbury
Rosenberg, S., American Univ. Beirut '39, Bridgeport
Rosenthal, B. B., N. Y. U. '30, Milford
Rosenthal, E., Munich '25, Hartford
Rosenthal, I., Long Island '10, South Norwalk
Rosenthal, R. L., Long Island '38, Branford
Rosner, F., Vienna '37, Bridgeport
Ross, A. M., Basel '35, Darien
Roth, F. E., N. Y. U. '25, Hartford
Roth, O., Vienna '37, New Haven
Rothblatt, R., Harvard '37, Willimantic
Rothschild, M. L., Paris '26, New Haven
Rourke, T. A., Columbia '37, Greenwich
Rowley, J. C., Harvard '06, West Hartford
Rowley, R. L., Yale '03, Hartford
Rowson, Walter, Jr., Yale '43, North Grosvernordale
Roy, J. L., Tufts '34, West Palm Beach, Florida (Windham County)
Rozen, A. A., Yale '37, New Haven
Rubin, A., Geneva '29, Hartford
Rubin, D., Cambridge '38, South Norwalk
Rubin, G. A., Edinburgh '32, New Haven
Ruby, M. H., Columbia '21, Waterbury
Ruby, R. J., Baylor '36, Waterbury
Rudnick, C. J., Long Island '17, Bridgeport
Ruiz, R. R., Havana '43, Danbury
Rup, E. C., Georgetown '43, Hartford
Russell, G. G., Harvard '19, Hartford
Russell, J. J., N. Y. Homeo. '87, Putnam
Russell, T. H., Yale '10, New Haven
Russell, W. I., Yale '09, New Haven
Russman, C., Tufts '23, Middletown
Russo, J. D., Yale '16, New Haven
Russo, J. N., Vermont '45, Hartford
Russo, R. D., Georgetown '43, Bridgeport
Ryan, A. J., Columbia '40, Meriden
Ryan, F. J., Tufts '35, Hartford
Ryan, V. G., Yale '34, Portland
Ryder, C. F., Western Reserve '33, Stamford
Ryder, R. H., P. & S., Balt. '13, Waterbury
Ryder, W. H., Jefferson '20, New Haven
Ryley, R. N., Yale '39, Mystic
Rynard, W. M. W., Toronto '24, Stamford

Sabia, D. J., Marquette '36, Stamford
Sabloff, J., Long Island '34, Hartford
Sachs, B., N. Y. U. '37, Hartford
Sachs, K., Vienna '35, Muskogee, Oklahoma (New Haven)
Sadusk, J. F., Jr., Johns Hopkins '35, Washington, D. C. (New Haven County)
St. John, L. A., Fordham '20, Hartford
Salinger, R., Johns Hopkins '25, New Haven
Salter, W. T., Harvard '25, New Haven
Saltzman, J. A., N. Y. Homeo. '33, Waterbury
Salvin, B. L., George Washington '21, Hartford
Samponaro, N., Johns Hopkins '29, Torrington
Samson, D. P., Columbia '43, Thomaston
Sanderson, R. V., Vermont '20, Winsted
Sandulli, G. R., Tufts '29, Waterbury
Sanford, C. E., Yale '06, Seattle, Wash. (New Haven County)
Santoro, G. M., Cornell '24, Waterbury
Saposnik, J. J., Howard '33, West Haven
Satti, C. J., Yale '23, New London
Saunders, A. I., Tufts '42, Roxbury, Mass. (New Haven County)
Saunders, G. R., Cornell '41, Old Saybrook
Sawyer, J. D., Vermont '44, Jewett City
Sayers, D. O'C., Tufts '35, Topeka, Kansas (New Haven County)
Sayers, J. J., Tufts '35, Hartford
Scafarello, P. J., Tufts '26, Hartford
Scalzi, L. C., Bologna '37, Bridgeport
Scanlon, J. J., Georgetown '35, South Norwalk
Scanlon, T. F., Yale '07, Norwalk
Scarbrough, M. McR., Yale '07, New Haven
Schaefer, A. M., Yale '25, Hartford
Schaefer, J., Tufts '17, East Hartford
Schatten, S. S., N. Y. U. '31, West Hartford
Schechtman, C. T., Vermont '26, New Britain
Schiavetti, A., Tufts '30, Stafford Springs
Schillander, C. A., Tufts '09, Somers
Schmidt, N. L., Vanderbilt '27, Stamford
Schnap, I., Long Island '29, East Hartford
Schneider, W., George Washington '30, Rockville
Scholl, R. F., Yale '12, New Haven
Schopick, L. E., Zurich '35, Bridgeport
Schuman, D. H., Columbia '22, Hartford
Schupack, S. D., Tufts '24, New Britain
Schwartz, H. N., Med. Coll. of Va. '37, Hartford
Schwartz, P. E., Tufts '31, Portland
Schwarz, H. P., Vienna '38, Colchester
Sciortino, M. V., Naples '37, Bridgeport
Scott, C. R., Yale '19, New Haven
Scott, J. C., Pennsylvania '33, West Chester, Penn.
Scoville, W. B., Pennsylvania '32, Hartford
Scully, M. R., Columbia '41, Bridgeport
Scully, R. T., Georgetown '35, New Britain
Seabury, R. B., Harvard '18, New Haven
Sears, L., Harvard '29, Norwich
Segal, J. A., Tufts '28, Manchester
Segel, S., Vermont '35, Norwich
Segnalla, E., Yale '12, New Haven
Seibert, A. F., Yale '27, Hartford
Seideman, R. M., Long Island '36, Hartford
Seigle, S. P., Harvard '40, East Hartford
Sekerak, A. J., Maryland '22, Bridgeport
Sekerak, R. A., Maryland '29, Bridgeport
Sekerak, R. J., Maryland '34, Bridgeport
Selleck, N. B., Long Island '24, Danbury
Sellew, R. C., Yale '98, Canaan
Sellew, R. C., Jr., Long Island '36, Canaan
Senfield, M. M., Vienna '20, Ansonia
Serafin, P. J., N. Y. U. '21, New Haven
Serbin, A. F., Rush '33, Hartford
Serena, F. A., Hahnemann '40, South Norwalk
Serena, J. M., Hahnemann '41, South Norwalk
Serrell, H. P., Cornell '32, Greenwich
Sette, A. J., George Washington '27, Stamford
Sewall, S., Maryland '37, West Hartford
Shaffer, I. G., Jefferson '40, Reading, Pa. (New Have County)
Shain, J. H., Tufts '28, Norwalk
Shaw, L. E., Wom. Med. Coll. Pa. '22, Greenwich
Shay, F. L., Tufts '25, New Haven
Shea, C. J., Maryland '33, Bridgeport
Shea, D. E., Loyola '17, Hartford
Shea, J. F., P. & S., Balt. '11, Bridgeport
Shea, M. S., Vermont '21, New Haven
Shea, J. P., N. Y. U. '46, Milford
Shea, V. T., Tufts '31, Waterbury
Sheahan, W. L., P. & S., Balt. '12, New Haven
Shearer, J. K., Albany '43, Waterbury
Sheehan, M. T., Yale '10, Wallingford
Sheiman, M., Michigan '39, Bridgeport
Sheiman, S. C., Michigan '40, Bridgeport
Shenker, B. M., N. Y. Med. Coll. '38, Middletown
Shepard, M. D., N. Y. U. '37, Hartford
Shepard, W. M., Columbia '29, Putnam

epherd, W. G., Toronto '08, Hazardville
ermak, J. V., Vienna '19, Old Greenwich
erman, B., George Washington '29, Bridgeport
erman, I. J., Johns Hopkins '40, Bridgeport
erman, S. H., Columbia '34, Stamford
erwood, H., N. Y. Med. Coll. '37, Middletown
erwood, P. M., Boston '42, Hartford
irk, S. M., Hahnemann '97, Wallingford (Fairfield County)
oller, N. A., Hahnemann '43, Bridgeport
oup, H. B., Jr., Indiana '35, Westport
ull, J. C., Harvard '36, Hartford
ulman, D. N., Johns Hopkins '17, Hartford
umacker, H. B., Jr., Johns Hopkins '32, Indianapolis, Ind. (New Haven County)
ure, A. L., Tufts '27, New Haven
ge, A. G., N. Y. Med. Coll. '43, Stratford
gal, J. B., Yale '23, Hartford
gel, H., Tufts '34, New Haven
es, R. F., Yale '35, Yonkers, N. Y. (Hartford County)
iciano, R. A. V., Hahnemann '24, Bristol
ls, T. H., Yale '27, Newington
ver, G. B., Tufts '37, Hartford
verberg, S. J., Columbia '21, New Haven
mmons, E. M., Yale '23, Southington
non, B., Washington '31, Middletown
non, L. G., N. Y. U. '27, South Norwalk
nonds, J. R., Vermont '38, Washington
nonton, F. F., Maine '03, Philadelphia, Penn. (Hartford County)
nses, J. P., Tufts '37, Bridgeport
vak, G. C., Cincinnati '43, Ansonia
iff, S. E., Hahnemann '03, New Haven
laver, J., Michigan '37, Waterbury
ater, D., N. Y. Med. Coll. '40, Hamden
ater, M., Yale '24, Hamden
avin, J. E., Vermont '12, Waterbury
ossberg, D. S., Tufts '34, Hartford
ysz, L. B., Boston '27, New Britain
nilgin, V. E., George Washington '38, New London
nirnow, M. R., Yale '06, New Haven
nith, A. C., P. & S., Balt. '10, Danbury
nith, B. A., Yale '40, Norwich
nith, C. L., N. Y. U. '41, Hartford
nith, C. S., Hahnemann '16, New Haven
nith, D. P., Yale '12, Meriden
nith, E. L., Yale '96, Waterbury
nith, E. R., Yale '40, Meriden
nith, E. T., Yale '97, West Hartford
nith, F. DeW., Hahnemann '10, Guilford
nith, F. F., Howard '30, New Haven
nith, F. M., Vermont '11, Willimantic
nith, G. A., Johns Hopkins '07, Long Hill
nith, G. M., Columbia '05, Pine Orchard
nith, H. E., Columbia '15, Middlefield
nith, J. A., Western Reserve '35, Waterbury
nith, J. J., Maryland '30, Bridgeport
nith, J. T., Long Island '41, New Haven
nith, L. M., Tufts '37, Stamford
nith, M., N. Y. U. '83, New Haven
nith, N. N., Yale '24, New Haven
nith, P. L., Queens '19, Hartford
nith, S. M., Tufts '20, Danbury
nith, S. R., Med. Chi. Phila. '16, Bridgeport
nith, V. J., Pennsylvania '20, New Britain
nith, W. B., Pennsylvania '22, Hartford
nith, W. E., Michigan '10, Stamford
nith, W. F., Cornell '34, Hartford
nith, W. L., Columbia '37, Hartford
nykowski, B. L., P. & S., Balt. '11, Bridgeport
Snavely, J. G., Yale '41, Stamford
Snavely, M. E., Yale '25, West Haven
Sneidman, G. I., Virginia '36, Hartford
Snelling, P. W., Harvard '21, Hartford
Snoke, A. W., Stanford '33, New Haven
Snurkowski, C. V., Georgetown '25, New Haven
Sohler, T. P., Freiburg '35, Hartford
Soifer, I. T., Creighton '26, Hartford
Sollosy, A., Tufts '27, Bridgeport
Solomkin, M., St. Louis '42, Chicago, Ill. (Hartford County)
Solomon, C. I., Yale '25, Meriden
Solomon, R. Z., Yale '39, Meriden
Soltz, T., Jefferson '11, New London
Solway, R. I., Toronto '40, Westport
Soreff, L., Tufts '32, East Hampton
Spector, N., Tufts '24, Willimantic
Speight, H. E., Georgetown '27, Middletown
Spekter, L., Rochester '33, Hartford
Spencer, S. B., N. Y. U. '41, Madison
Sperandeo, A., Yale '25, New Haven
Sperry, F. N., Yale '94, New Haven
Spiegel, C. M., Hahnemann '36, New Haven
Spignesi, J. T., Georgetown '30, Wallingford
Spillane, B., Tufts '16, Hartford
Spinelli, N. V., Marquette '39, Bridgeport
Spinner, S., Tufts '35, New Haven
Sponzo, J. J., Tufts '38, Hartford
Sprague, C. H., Columbia '04, Bridgeport
Squier, R. R., Johns Hopkins '26, Greenwich
Squillacote, V. J., Rome '34, New Britain
Squillante, O. J., Maryland '40, Rockville
Stahl, W. M., Maryland '14, Danbury
Stahl, W. M., Jr., Harvard '46, Danbury
Standish, E. M., Harvard '22, Hartford
Standish, F. B., Yale '03, New Haven
Standish, H. C., Cornell '28, West Hartford
Standish, J. H., N. Y. U. '95, Hartford
Standish, W. A., Yale '25, Hartford
Staneslow, J. S., Cornell '26, Waterbury
Stankard, W. F., Jefferson '38, Stamford
Starr, R. M., Yale '26, New London
Starr, R. S., Columbia '01, Hartford
Starrett, J. E., Tufts '30, Stamford
Staub, J. H., Long Island '99, Stamford
Steege, T. W., Yale '38, Hartford
Stein, J. D., Columbia '44, Bronx, N. Y. (New Haven County)
Steinberger, L., Royal Hungarian Eliz. '37, South Norwalk
Steincrohn, P. J., Maryland '23, Hartford
Stephens, D. C., Wayne '32, Newtown
Stephenson, C. W., Harvard '22, Hartford
Sterrett, R. A., Cornell '39, Southport
Stetson, C. G., Cornell '35, Milford
Stetson, H. P., Boston '41, Southington
Stetson, H. W., Vermont '06, Milford
Stettbacher, H. J., Harvard '22, Waterbury
Stevens, H. G., Maryland '04, New Milford
Stevens, M. A., Yale '29, New York, N. Y. (New Haven County)
Stevenson, W. R., Boston '31, Bristol
Stewart, L. Q., Yale '33, West Hartford
Stietzel, E. E., Columbia '34, South Norwalk
Stilson, C., Yale '42, New Haven
Stone, E. L., Johns Hopkins '20, New Haven
Stone, H. R., Johns Hopkins '04, Clinton
Stone, M. J., Rush '22, Stamford
Storms, W. F., Harvard '30, Wethersfield
Storrs, R. W., Harvard '20, Hartford
Stowe, L. M., Yale '38, New Haven

Strauss, M. J., Columbia '17, New Haven
Strayer, E. M., Columbia '33, Stratford
Strayer, L. M., Jr., Harvard '30, Bridgeport
Street, J. M., Duke '42, New Milford
Stretch, J. E., George Washington '28, Simsbury
Strickland, H., McGill '30, Meriden
Stringfield, O. L., Univ. & Bellevue '16, Stamford
Sturtevant, J. M., Bowdoin '14, New London
Stygar, J. S., St. Louis '33, Derby
Sulkowitch, H., Johns Hopkins '32, New Haven
Sullivan, A. B., Yale '38, West Hartford
Sullivan, A. F., Jefferson '42, Waterbury
Sullivan, C. N., McGill '30, New Britain
Sullivan, D., Univ. & Bellevue '97, New London
Sullivan, J. F., Columbia '94, New Haven
Sullivan, T. J., Yale '17, New Haven
Sulman, M., Columbia '36, New London
Sunderland, P. U., N. Y. Homeo. '94, Danbury
Sunderland, W. A., Yale '26, Danbury
Sundquist, A. B., Tufts '33, Manchester
Suplicki, J. W., Tufts '26, Norwich
Sussler, D., Fordham '16, Norwich
Sutch, G. C., Minnesota '41, Middletown
Sutherland, F. A., Harvard '26, Torrington
Sutton, P., Vienna '36, Groton
Swan, H. C., Tufts '03, Hartford
Swarts, W. B., Pennsylvania '34, Greenwich
Sweet, A. N., Maryland '18, Middletown
Sweet, J. H. T., Jr., Tufts '12, Hartford
Swenson, A. C., Yale '02, Waterbury
Swett, N. P., N. Y. U. '46, East Hartford
Swett, P. P., Univ. & Bellevue '04, Bloomfield
Swift, W. E., Jr., Columbia '40, New York (New Haven County)
Swirsky, M. Y., N. Y. Med. Coll. '39, New Haven
Sword, B. C., N. Y. Homeo. '18, Yonkers, N. Y. (New Haven County)
Szanton, V. L., Duke '36, Derby
Szlemko, E. A., Geneva '38, Groton

Taffel, M., Yale '31, New Haven
Tait, A. A., Illinois '30, Togus, Maine (Hartford County)
Talbot, H. P., Maryland '27, Hartford
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Thompson, C. G., N. Y. Homeo. '18, Norwich
Thompson, H. G., Harvard '17, Hartford
Thompson, L. E., Boston '25, Meriden
Thompson, S. A., Cornell '23, Greenwich
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Thoms, H., Yale '10, New Haven
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Tiebout, H. M., Johns Hopkins '21, Greenwich
Tileston, W., Harvard '99, New Haven
Timm, A. B., Jr., Harvard '40, Milford
Tinkess, D. E., McGill '25, Greenwich
Tirella, F. F., Tufts '37, Bristol
Tisher, P. W., Iowa '35, New Britain
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Tolk, N. R., N. Y. U. '20, Bridgeport
Toll, N., Charles Univ., Prague '27, Middletown
Tomaino, F. F., Yale '29, Danbury
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Tonken, L. C., Tufts '34, Hartford
Tortolani, A. P., McGill '34, Plainville
Tortora, F., Rome '40, New Haven
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Truex, E. H., Jr., Harvard '36, Hartford
Tuch, M., Univ. & Bellevue '06, Hartford
Tucker, C. A., Tufts '38, Hartford
Tunick, G. L., Jefferson '35, Greenwich
Turbert, E. J., P. & S., Balt. '04, Hartford
Turchik, F., Jefferson '27, Bridgeport
Turco, V. J., Tufts '41, Hartford
Turetsky, S., Baylor '36, Bridgeport
Turkington, C. H., Johns Hopkins '07, Litchfield
Turnley, W. H., Virginia '24, Stamford
Tutles, A. J., Tufts '30, Bridgeport
Twachtman, E., Virginia '36, New Canaan
Twaddle, P. H., Yale '35, Hartford
Tylec, L. L., Virginia '35, Naugatuck
Tyler, M., Johns Hopkins '17, New Haven
Tynan, J. G., Tufts '42, Waterbury

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Ursone, F. D., Tufts '29, Norfolk
Uvitsky, I. H., Boston '27, Bridgeport

Vadasz, E., Budapest '29, Meriden
Vail, G. F., Pennsylvania '02, Hartford
Vail, T. E., Johns Hopkins '11, Thompsonville
Valenski, T. J., Tufts '37, Thompsonville
Van Antwerp, L. D., Michigan '31, Chicago, Illinois (New Haven County)

an Cor, C. A., Vermont '14, Middletown
an Kleeck, E., Columbia '12, Hartford
an Leuvan, J. S., Yale '27, Meriden
an Strander, W. H., Vermont '00, Hartford
an Tassel, W., N. Y. U. '27, Darien
an Wart, W. H., Harvard '22, Hartford
astola, A. P., Fordham '12, Waterbury
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erie, K. E., Tufts '44, New London
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etrano, S. A. Naples '37, New Britain
ickers, J. L., Johns Hopkins '24, Greenwich
inci, V. J., N. Y. U. '39, Middletown
iola, C. P., Tufts '36, Milford
ioni, R. E., Naples '35, Bridgeport
ogel, F. S., Vienna '27, Bristol
ollero, A., Tufts '30, New Haven
ollmer, J. W., Yale '06, Norwalk
on Glahn, H. D., Duke '42, Old Lyme
on Salzen, C. F., Columbia '36, Hartford
oris, J. V. B., Columbia '41, Darien

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Wertheimer, J., Univ,. & Bellevue '18, Waterbury
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Whalin, M. L., Women's Med. Coll. Pa. '35, Storrs
Whalley, E. J., Tufts '43, Waterbury
Wheatley, L. F., Tufts '03, New Haven
Whipple, B. N., Yale '07, Bristol
Whitcomb, B. B., McGill '35, Hartford
White, B. V., Harvard '34, Hartford
White, E. P., Vermont '37, Hartford
White, H. T., Western Reserve '34, Meriden
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Wiepert, W. M., Yale '37, Avon
Wies, C. H., Yale '32, New London
Wies, F. A., Yale '33, New Haven
Wight, W. E., Bowdoin '20, Thomaston
Wilcox, F. C., Medical Evangelists '34, Waterbury
Wilcox, L. M., Tufts '33, Terryville
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Wilk, E. K., Baylor '36, Middletown
Wilkinson, A. G., Maryland '36, New Haven
Willard, W. R., Yale '34, New Haven
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Williams, E. E., Columbia '23, Naugatuck
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Willis, T., Yale '36, Norwalk
Willner, O., Vienna '05, New Haven
Wills, A. A., Jr., Yale '31, Hartford
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Wilson, W. A., Louisville '28, Hartford
Wilson, W. R., Johns Hopkins '25, New Haven
Wineck, M. S., Vermont '15, Hartford
Winer, P., St. Louis '44, New Haven
Winternitz, M. C., Johns Hopkins '07, New Haven
Winters, H. W., Johns Hopkins '29, Bristol
Winters, J. T., Pennsylvania '31, West Hartford
Winters, S., Baylor '20, New Haven
Witter, O. R., Columbia '01, Hartford
Wolfson, D., Boston '33, Bethel
Wolfson, S., Sheffield, England '37, New Britain
Wood, F. O., Rush '31, Hartford
Woodford, C. N., Louisville '08, Hartford
Woodford, F. B., Yale '24, Ridgefield
Woodruff, L. M., Yale '37, Belmont, Mass. (New Haven County)
Woodward, H. B., Johns Hopkins '12, Bristol
Woodward, J. C., Columbia '35, New London
Woodworth, J. A., Syracuse '39, Moosup
Wool, J. M., N. Y. Med. Coll. '41, New London
Worthen, T. W., Dartmouth '11, Hartford
Wrang, W. E., Jefferson '19, Middletown
Wray, E. H., Jr., Yale '32, Litchfield
Wright, H. S., Cornell '39, Greenwich
Wright, W. W., Harvard '19, Hartford
Wrona, E. A., Hahnemann '43, Stamford
Wulp, G. A., Michigan '30, Hartford
Wurtenberg, W. C., Yale '93, New Haven

Yakovlev, P. I., Paris '25, Middletown
Yannet, H., Yale '29, Southbury
Yasser, I., Colorado '40, Bridgeport
Yavis, J. C., Athens '18, New Haven
Yeager, C. F., Hahnemann '33, Bridgeport
Yerbury, C. C., N. Y. Med. Col. '16, Enfield
Yerbury, E. C., Boston '21, Middletown
Yergason, R. M., Columbia '09, Hartford
Yesner, R., Tufts '41, Newington
Yoburn, M. M., Boston '39, Danbury
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Young, W. G., Toronto '30, Hartford
Yudkin, A. M., Yale '17, New Haven

Zaff, F., Michigan '37, New Haven
Zaglio, E. R., Columbia '33, Manchester
Zagraniski, R. J., Yale '42, New Haven
Zariphes, C. A. P., Boston '24, Hartford
Zarkin, O. H., Tufts '37, Hartford
Zaur, I. S., Yale '32, Bridgeport
Zavadier, N., Zurich '18, Bridgeport
Zeman, B., Kentucky '08, Hartford
Zeman, M. S., Louisville '36, Hartford
Zerkowitz, F., Graz '22, Waterbury
Zielinski, J. B., Jefferson '34, Bridgeport
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Zwick, F., Vermont '13, New Britain

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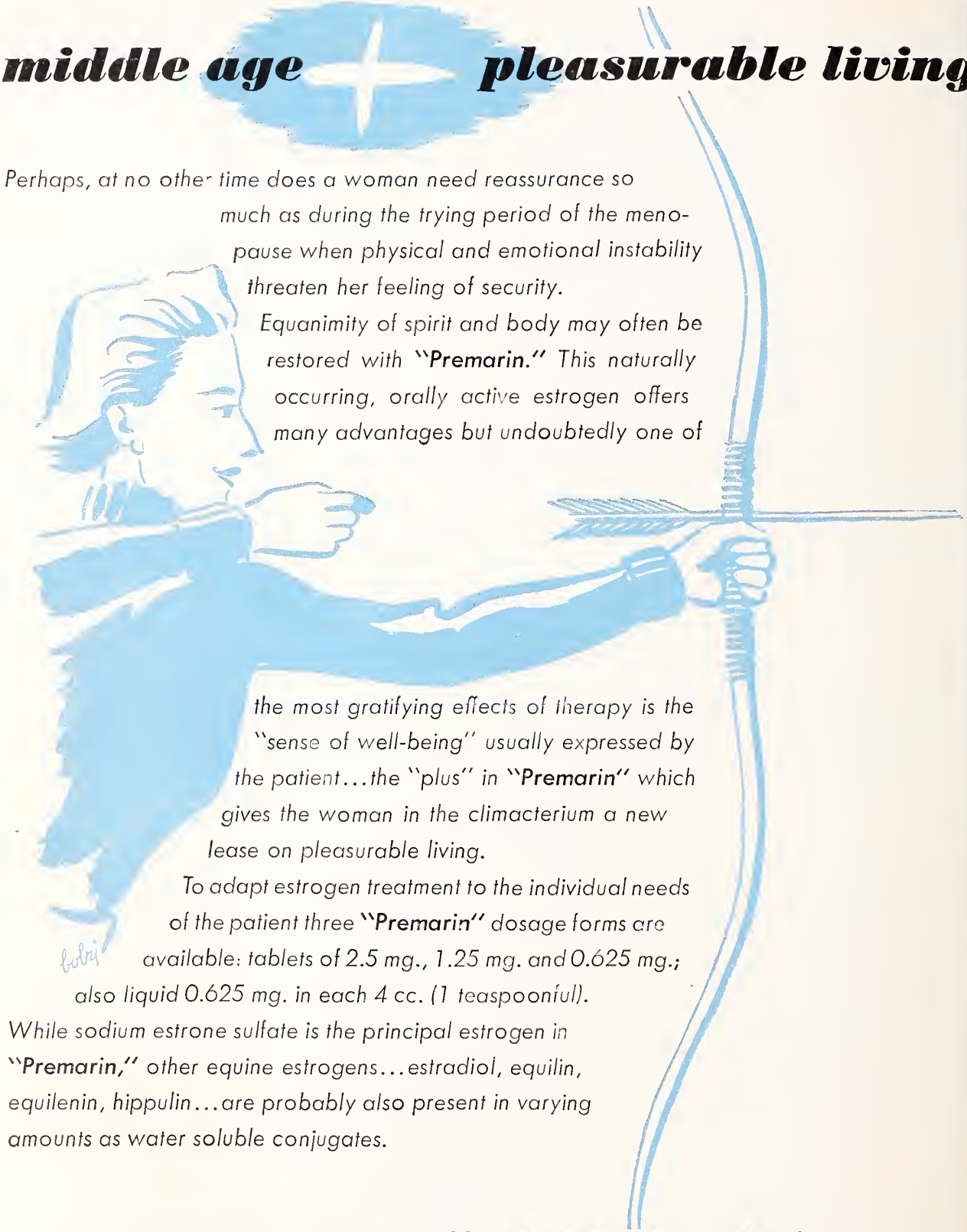
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The
CONNECTICUT STATE MEDICAL JOURNAL

OL. XII SEPTEMBER, 1948 No. 9

TWENTY-THIRD CLINICAL CONGRESS

of the

CONNECTICUT STATE MEDICAL SOCIETY

and the

YALE UNIVERSITY SCHOOL OF MEDICINE

YALE LAW SCHOOL AUDITORIUM
Grove Street, New Haven

NEW HAVEN HOSPITAL AND THE SCHOOL OF MEDICINE
Cedar Street, New Haven

September 14, 15, 16, 1948

Committee on the Clinical Congress

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Cole B. Gibson, *Treasurer*

Hugh L. Dwyer, *Program*
David H. Clement
Barnett Greenhouse
C. Stanley Hitchins
Arnold N. Janzen
Burness E. Moore
Max Taffel
William R. Wilson, *Arrangements*

TUESDAY, SEPTEMBER 14

MORNING SESSIONS

Auditorium of the Law School

9:15 Registration

10:00 Headache Mechanisms
Harold G. Wolff, *New York*

10:45 Degenerative Liver Disease
Chester M. Jones, *Boston*

11:30 Some Reactions to Antibiotics
Leon Goldman, *Cincinnati*

12:00 Modern Aspects of Malignant Lymphomas and Leukemias
Lloyd F. Craver, *New York*

1:00 Luncheon, New Haven Hospital

AFTERNOON SESSIONS

New Haven Hospital and Yale Medical School

2:30 Clinical Implications of Attacks of Unconsciousness and Convulsions in Middle Aged Persons
Paul I. Yakovlev, *Middletown*

Group Management of Ulcerative Colitis
Erich Lindemann, *Boston*

Neurosurgical Measures for the Control of Intractable Visceral Pain
James C. White, *Boston*

3:45 Delays and Errors in the Diagnosis of Brain Tumors
Frederick C. Redlich, *New Haven*

Recent Advances in the Chemical Control of Insects of Interest to the Practitioner
Leon Goldman, *Cincinnati*

Backache
John R. Cobb, *New York*

WEDNESDAY, SEPTEMBER 15

MORNING SESSIONS

Auditorium of the Law School

9:15 Registration

10:00 Practical Importance of the Rh Factor in Clinical Medicine
Louis K. Diamond, *Boston*

10:30 Management of Heart Disease in Pregnancy
Burton E. Hamilton, *Boston*

11:10 New Developments of Clinical Interest in Cardiovascular Diseases
Charles C. Wolferth, *Philadelphia*

11:40 Current Trends in the Diagnosis and Treatment of Diabetes
Elliott P. Joslin, *Boston*

1:00 Luncheon, New Haven Hospital

AFTERNOON SESSIONS

New Haven Hospital and Yale Medical School

2:30 Hemophilus Influenzae Infections in Children
Hattie E. Alexander, *New York*

Panel Discussion on Diabetes
Elliott P. Joslin and others

Disorders of Menstruation
John Rock, *Boston*

3:45 Virus Respiratory Disease in Infants and Children
Richard G. Hodges, *Cleveland*

Diet in Hypertensive Vascular Disease
George A. Perera, *New York*

Infertility
Charles M. McLane, *New York*

4:30 The Clinical Congress Committee cordially invites registrants at the Congress to attend a reception in the Beaumont Room of the Historical Library, Sterling Hall of Medicine

THURSDAY, SEPTEMBER 16

MORNING SESSIONS

Auditorum of the Law School

9:15 Registration

10:00 Treatment of Compound Injuries of the Hand
Michael L. Mason, *Chicago*

10:30 Dynamic Therapeutics in Chronic Disease
Howard A. Rusk, *New York*

11:10 Intrinsic Asthma
Francis M. Rackemann, *Boston*

11:40 Obliterative Arterial Disease of the Lower Extremities
Leland S. McKittrick, *Boston*

1:00 Luncheon, New Haven Hospital

AFTERNOON SESSIONS

New Haven Hospital and Yale Medical School

2:30 Panel Discussion on Urinary Tract Infections
Clyde L. Deming and others

Panel Discussion on Allergy
Francis M. Rackemann and others

Panel Discussion on Surgery of the Hand and Surgery in Peripheral Vascular Disease
Michael L. Mason, Leland S. McKittrick

3:45 Panel Discussion on Hearing
William G. Hardy, *Baltimore*, and others

Psychotherapy in General Practice
Henry M. Fox, *Boston*

Demonstration of Prosthetics
Burke M. Snow, Major, MC–USA, *Washington, D. C.*

The Alumni of the New Haven Hospital Staff are invited to be the guests of the Resident Staff, New Haven Unit of Grace-New Haven Community Hospital, at a buffet supper in the Doctor's Lounge on Thursday, September 16, at 6:00 p. m.

General Information

REGISTRATION FEE

The registration fee for members of the Connecticut State Medical Society is $3.00. The fee for non-members is $5.00. Payment of the registration fee will admit to all sessions of the Congress.

Hospital residents, interns and medical students will be admitted to sessions without charge if a statement of their position, signed by an official of the hospital or medical school, is presented at the registration desk.

MEETING PLACE

The morning sessions will be held in the auditorium of the Law School, Grove Street between High and York, New Haven. The afternoon sessions will be held in the New Haven Hospital and the School of Medicine.

TELEPHONE

All telephone messages will be received at New Haven, 5-8573.

LUNCHEONS

Cafeteria luncheons will be served at the New Haven Hospital on the three days of the Congress. The number of persons who can be served is limited and reservations should be made in advance.

PARKING

Parking of automobiles is restricted in the vicinity of the Law School and New Haven Hospital. Stickers for windshields will be provided.

REGISTER EARLY

Early registration will facilitate the work of the committee and save time for you at the Congress.

CANCER IN CONNECTICUT

A General Survey of Distribution and Incidence

Prepared by the Tumor Study Committee of the Connecticut State Medical Society in Collaboration with, and from Data Supplied by, the Cancer Registry of the Connecticut State Department of Health

CANCER as it exists in a mixed population is seen in unique perspective in the statistical material that has accumulated in Connecticut during the past twelve years. Statistical studies emanating from hospitals or clinics always tend to be affected by the selective factors that determine the patient population. The more than 37,000 records prepared by physicians of the State, and coded and analyzed in the Tumor Registry of the Connecticut State Health Department, form a base line against which changes in incidence, and the effects of treatment can be measured. The value of the records has been increased by the careful follow-up work of the tumor clinics and by the availability of microscopic proof of the diagnosis in 74.4 per cent of the cases. Thus they are an important source of clinical as well as of statistical information.

The material reported here includes all cases of cancer registered in Connecticut beginning with 1935. It is estimated from indirect evidence that these represent more than 90 per cent of all cases of cancer diagnosed in the State, except of course those of the skin or other superficial parts, many of which are treated by fulguration or minor surgical procedures without histological study. Cases first identified as carcinoma at autopsy also are included. A similar registry is being operated in Denmark, and it will be of interest to compare the results of the present survey with the Danish statistics when these are published. The population encompassed in the Danish registry, however, lacks the heterogeneity of that in Connecticut. In one sense this is a disadvantage. Little data have been published with which the Connecticut study can be compared. Information compiled by the United States Public Health Service* affords a comparison in certain planes. The Public Health report is based on a one year study o ten cities and the surrounding counties—none o which is in New England.

The present report is merely a factual statemen of the best available statistical data of cancer as i has existed in Connecticut during the past twelv years, and is intended as a general guide for th physician. Adjustments based on age, sex, and racia distribution will be necessary before the data ar

TOTAL NUMBERS OF CASES, PERCENTAGE INCIDENCE AND PERCENTAGE MICROSCOPICALLY PROVEN, OF VARIOUS FORMS OF CANCER

— CONNECTICUT 1935 THROUGH 1946 —

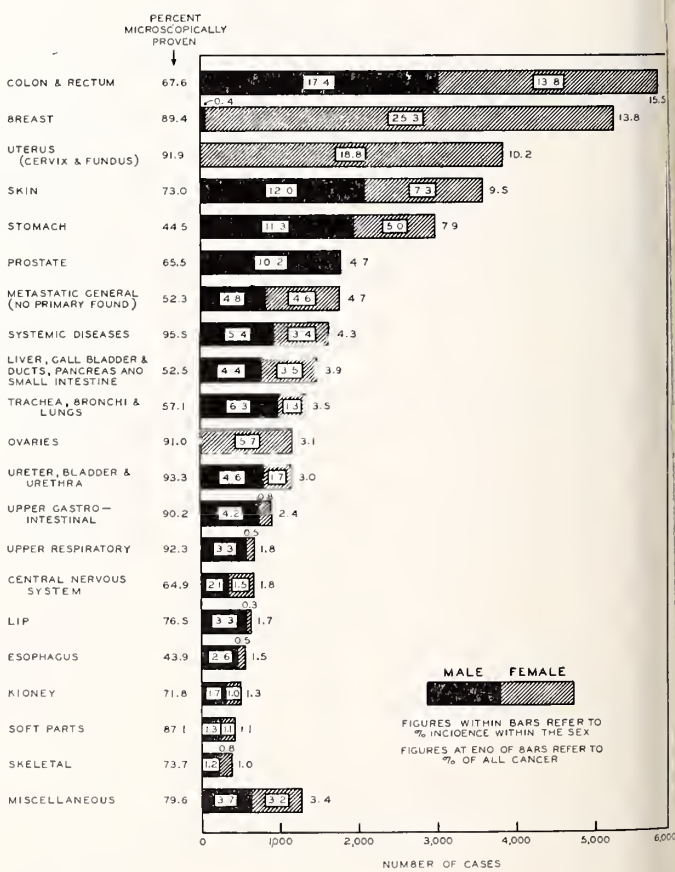


CHART 1

*Dorn, Harold F.: Illness from Cancer in the United States. U. S. Public Health Service. Reprint No. 2537 from: Public Health Reports, 59:33-48, 67-77, 97-115, 1944.

Publication of this report was aided by a grant from the Connecticut Cancer Society, Inc.

Cancer Registry of the Connecticut State Department of Health, Dr. Matthew H. Griswold (Chief); Eleanor J. Macdonald, Research Statistician

more generally applicable. Also the mass of clinical information available in the records remains for detailed analysis, to be carried out by interested and

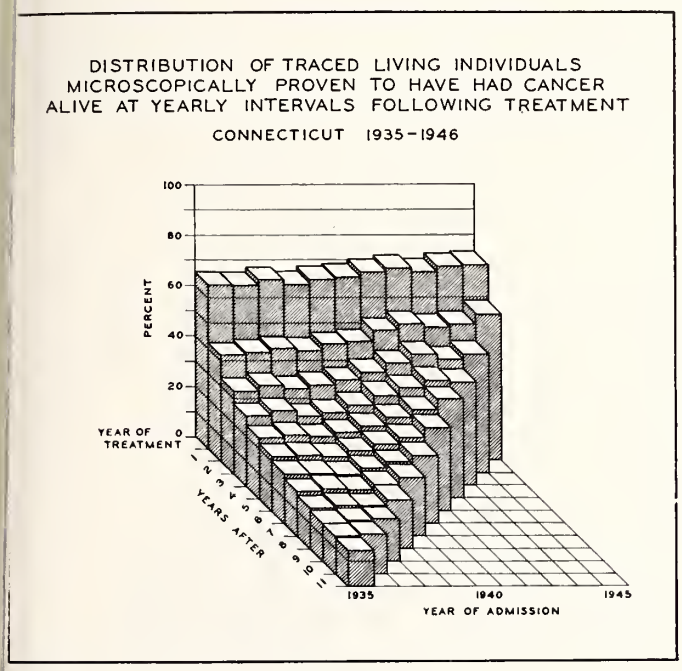


CHART 2

competent medical men in collaboration with well trained statisticians.

SCOPE OF THE STUDY—DEFINITIONS

Some idea of the scope of the study and the definitions employed in the classification of the tumors may be obtained from Chart 1. Cancers of the skin are included, not because the true incidence is thought to be represented, but merely to serve as background information by which the total incidence figures can be more intelligently evaluated. Under "Systemic Diseases" are included the lymphoblastomas, leukemias, mycosis fungoides, and allied conditions. The "Upper G.I. Tract" comprises tumors of the mucosa of the cheek, gingiva, floor of the mouth, palate and tongue. Under "Upper Respiratory Tract" are included the nasal cavity, paranasal sinuses, the pharynx, and the intrinsic and extrinsic laryngeal tissues. "Miscellaneous Tumors" are all of those not specifically named and charted.

The total length of each bar in Chart 1 indicates the number of patients registered during the twelve year period. The per cent microscopically proven is recorded at the left end of each bar. At the right of each bar appears the percentage of all cancer, represented by each variety of tumor, regardless of the sex of the patient. The number occurring in each sex is indicated by the shading, black for men, slanted lines for women. In each appropriately shaded segment there is recorded the percentage incidence among all tumors for that sex.

INCIDENCE DATA

Cancer in Connecticut has been more frequent in women than in men. Of the 37,863 cases registered beginning with 1935 and ending with 1946, 20,458

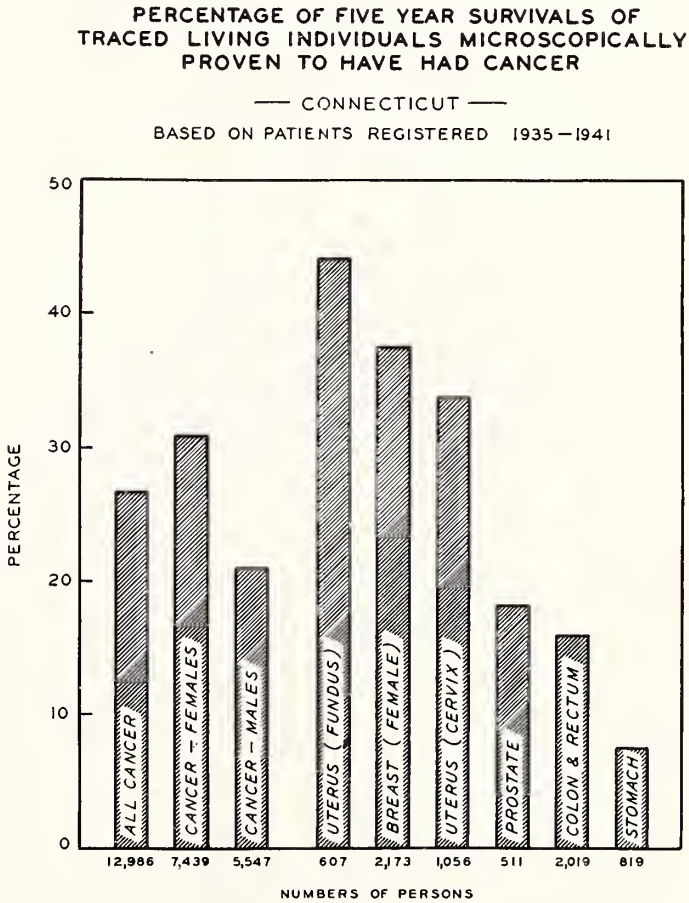


CHART 3

(54 per cent) occurred in women and 17,405 (46 per cent) in men. These are incidence figures representing the new cases registered year by year and do not represent "prevalence" by which is meant the cases under treatment at any one time.

The colon and rectum represent the most frequent sites of carcinoma in the population as a whole (15.5 per cent) and also of the male (17.4 per cent). In the female, however, cancer of the breast, which is almost a nonentity in the male, is by far the most important tumor (25.3 per cent) followed by cancer of the uterus (18.8 per cent). In contrast with other data cancer of the stomach in Connecticut appears to have a relatively low inci-

dence. In Dorn's study the incidence of cancer of the stomach among males was almost as great as that of cancer of the colon and rectum. The rates presented by Dorn are projected upon the urban population of the United States as a whole and are standardized for age.

In women, cancer of the genital system (breast, uterus, ovaries) constitutes 49.8 per cent of all

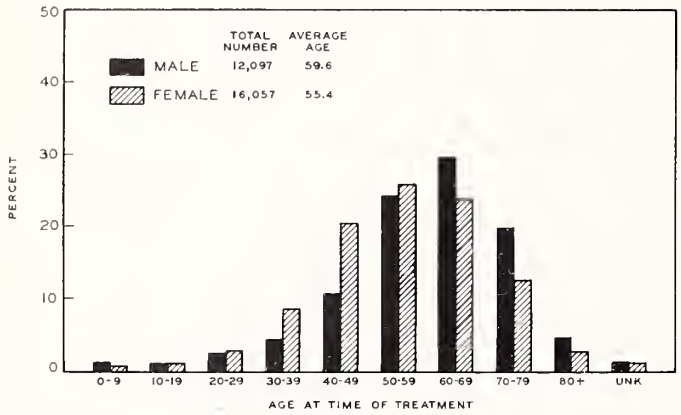


CHART 4

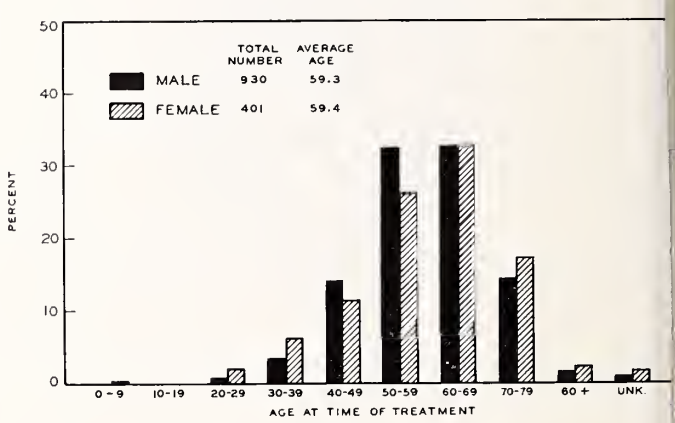


CHART 6

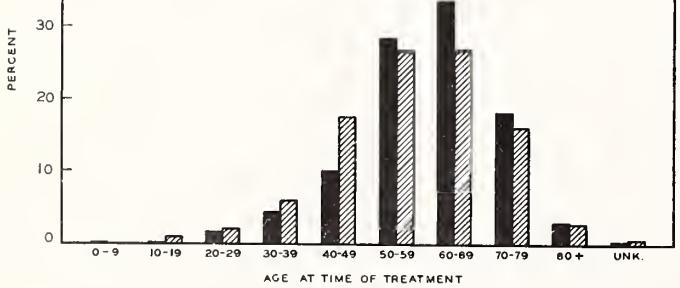


CHART 5

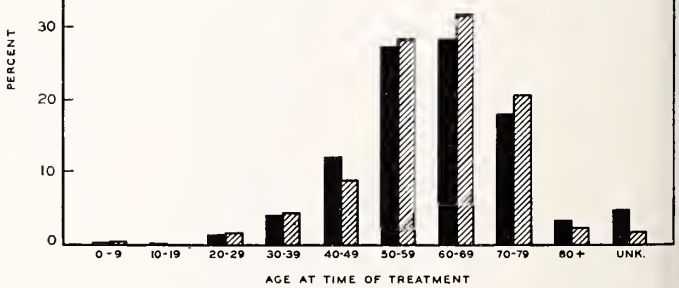


CHART 7

tumors. In men the tumors tend to be more variegated, although colon, rectum, and stomach together make up more than one quarter (28.7 per cent) of all tumors. There is a disparity in incidence in favor of the male in the great majority of tumors not peculiar to the female sex. This is especially pronounced among tumors of the lip, upper gastrointestinal tract, and esophagus, and of all parts of the respiratory tract.

SURVIVAL DATA

The general trend in survival for microscopical confirmed tumors is shown in Chart 2. If the cha is read from above obliquely downwards, the d crease in survival year by year after treatme becomes apparent. When the chart is read from le to right there appears to be a general improveme in survival rate among those patients first treate in the later years of the study. The factors responsible for this, whether earlier or better therapy, must be analyzed. The higher survival rates are not due to changes in the types of tumor that have been registered.

In evaluating such information the age distribution of the population must be considered. Many of the deaths occur not from cancer but from other causes in the generally advanced age group that is

nder consideration. Similar data are available for the arious types of tumor, but in general the construc- on of such a survival record as Chart 2 required reakdown into rather small groups even for the ost common neoplasms. Consequently significant ata are available only for the five-year survival ates.

cancer of the female genital system (fundus 44.2 per cent, cervix 33.8 per cent, and breast 36.7 per cent).

AGE INCIDENCE

The percentage distribution according to age when first treated of cancer in general, and of cer-

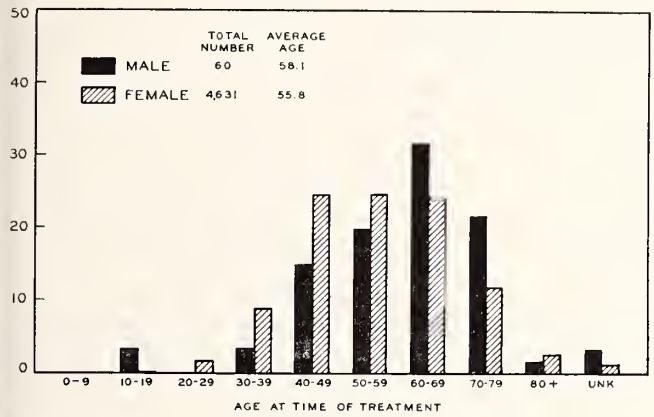


Chart 8

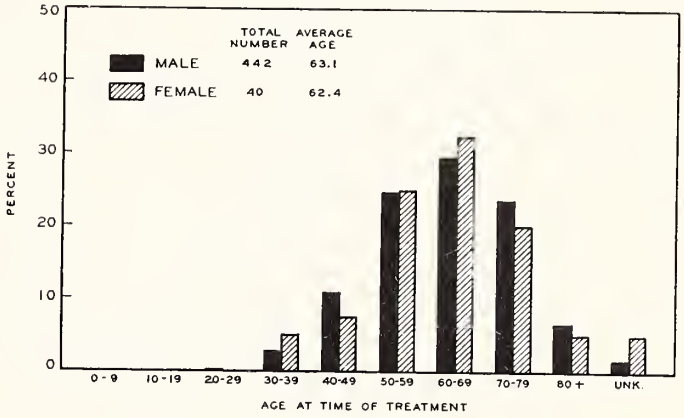


Chart 10

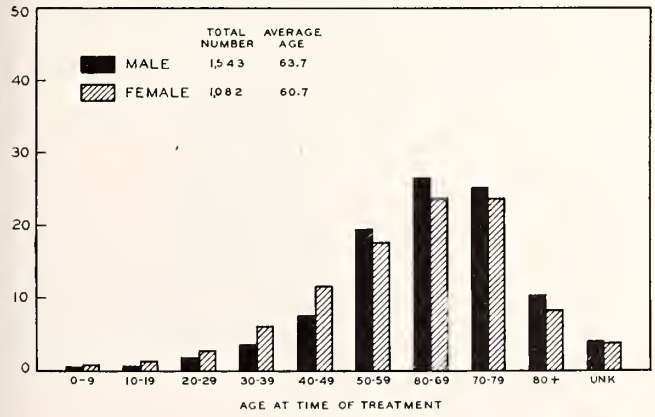


Chart 9

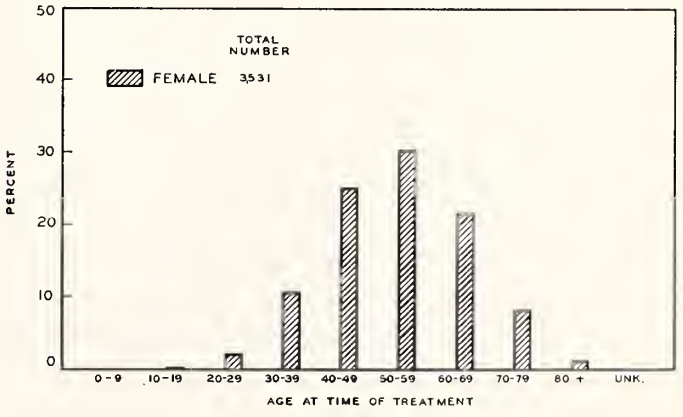


Chart 11

Chart 3 shows the percentages of 5 year survivals or all patients with cancer, whose distribution has been defined in Chart 1. In this population slightly over one-quarter (26.7 per cent) of persons registered between 1935 and 1941 survived 5 years. The survivors among the women (30.9 per cent) greatly exceed those among the men (21 per cent). Further analysis shows that this better outlook is associated chiefly with the relatively high survival rates in

tain special forms of the disease is presented in a series of graphs (Charts 4-18). Again, to increase the accuracy of the data, only microscopically proven cancer is considered. It must be emphasized that these graphs do not give the expected incidence of cancer in the various age groups. Likewise, since the data are given as percentages, some charts give undue prominence to certain rare tumors, e.g., cancer of the breast in the male (Chart 8).

In the first graph of the series it is apparent that females predominate among cancer patients less than 50 years of age and the males after 50. About a third (33.1 per cent) of the women with recorded cancer were below the age of 50, while only a fifth (20.1 per cent) of the men were below the 50th

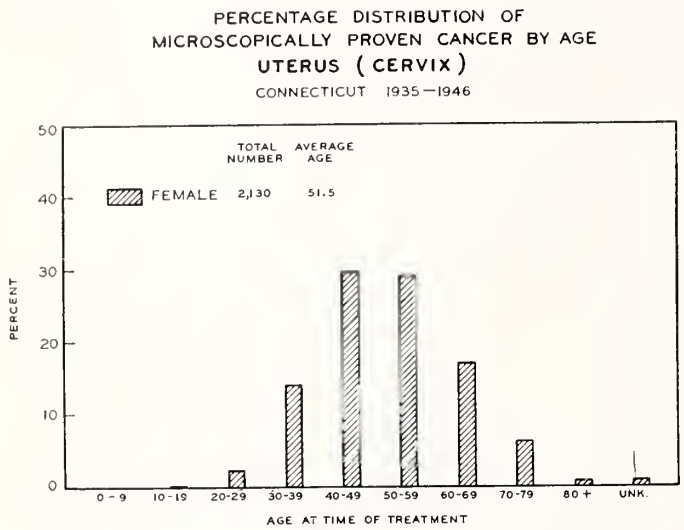


CHART 12

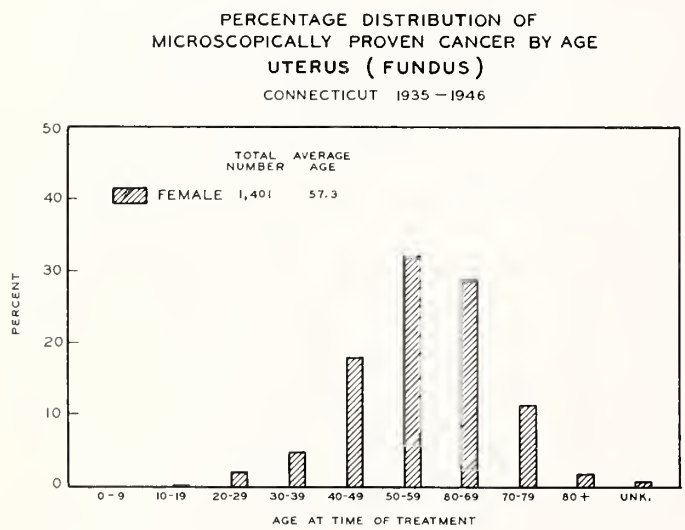


CHART 13

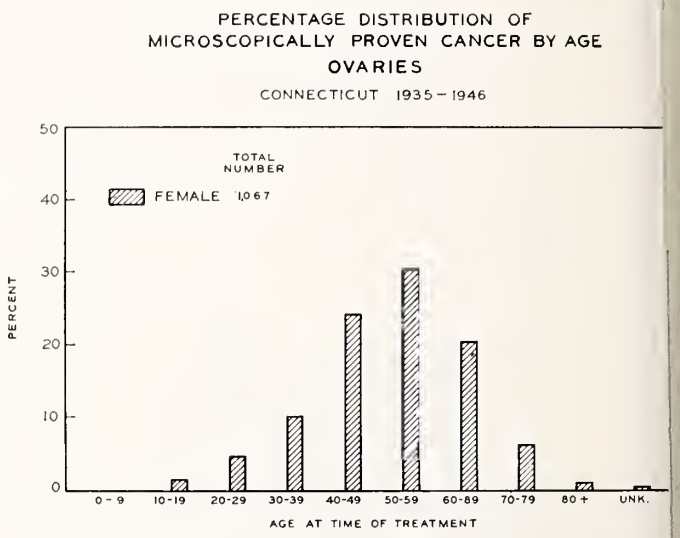


CHART 14

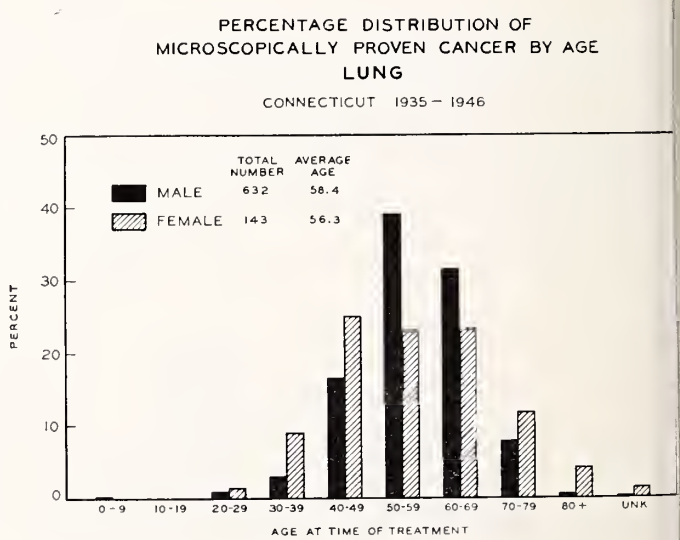


CHART 15

year. This same trend is apparent in the majority of charts dealing with special tumors (Charts 5, 8, 9, 15).

Most of the malignant lesions show a peak of incidence between the ages of 55 and 65 years. A notable exception is malignant disease of the skeletal system which has two peaks, one at about 20 years of age and another at about 60. Both the males and females in this group exhibit this double peak (Chart 17). A broad range of distribution among all age groups is apparent for the "systemic disease" (Chart 18). Cancer of the prostate occurs relatively late, with a sharp peak of incidence coming after 70 (Chart 16). As is well known the incidence of cancer of the cervix of the uterus has its peak at about 50 years of age while the crest of the curve for the fundus comes almost 10 years later (Charts 12 and 13).

Certain groups of tumors tend to have strikingly similar curves of age distribution. This is true of cancer of the uterus and cancer of the ovary (Charts 11 and 14). Likewise the curve for cancer of the skin resembles that of cancer of the lip, (Charts 9 and 10) except that there are relatively more of the former in the younger age groups. The curves for the stomach, and colon and rectum also are similar.

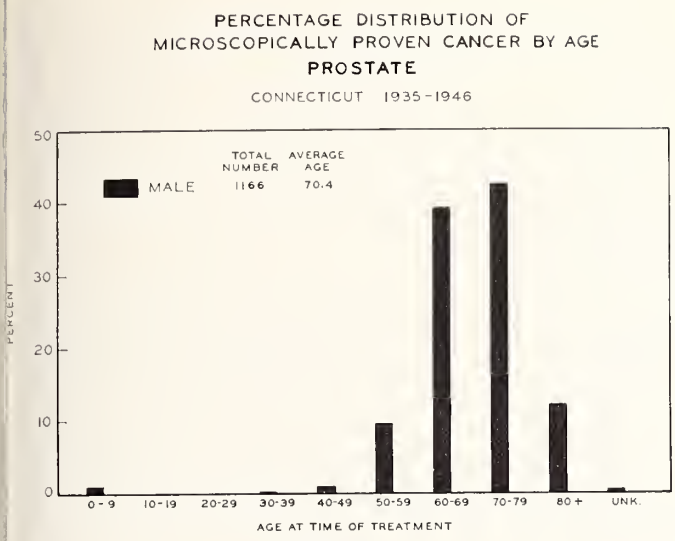


Chart 16

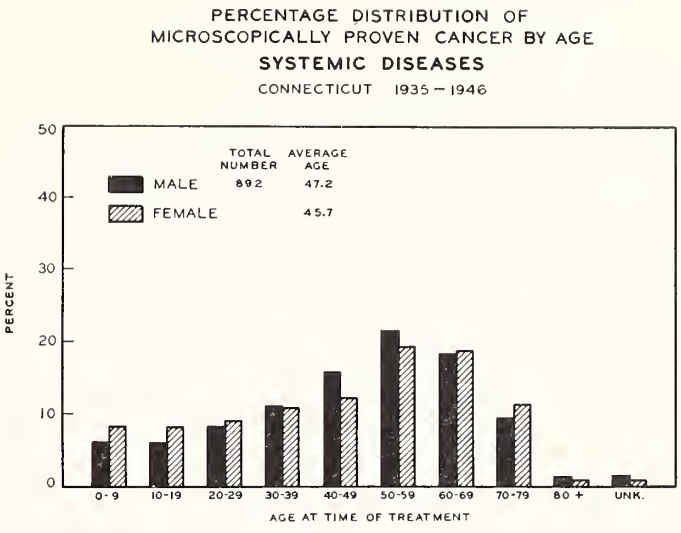


Chart 18

What etiological significance this information may have remains to be determined.

Such data concerning age incidence may have value in the planning of special diagnostic procedures. Inspection of the curve for cancer of the uterus (Chart 11) reveals that the Papanicolaou vaginal smear technique is likely to yield few positives if routinely applied to women less than 30 years of age, but that there is a significant proportion of tumors in the age group 30 to 39 years (14.1 per cent for cervix, 4.3 per cent for fundus). It would be desirable actually to direct a special effort toward that particular age group since evidence is accruing that "carcinoma in situ," which in experienced hands is often detectable by the Papanicolaou technique, may persist for some years before deeply invasive tumors develop. Likewise, in planning the diagnostic approach to other varieties of tumor, the chief efforts should be concentrated upon the age groups preceding those of maximal incidence since neoplasms may exist for considerable periods before reaching clinical levels.

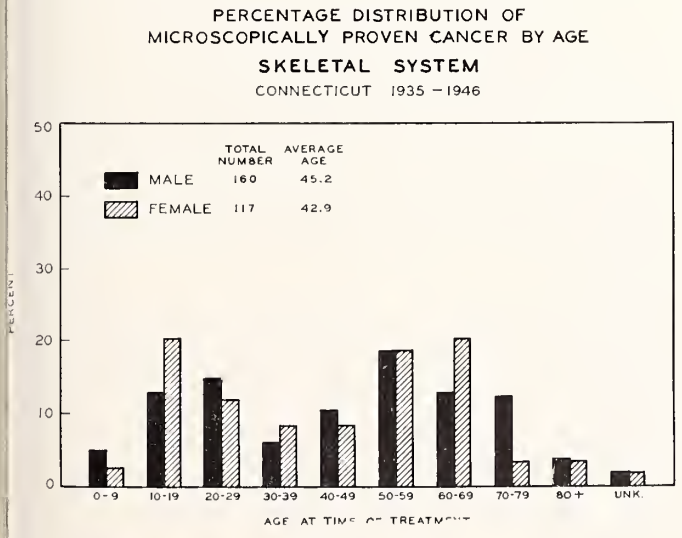


Chart 17

SUMMARY

A general view of the statistics of cancer as it has existed in the general population of Connecticut during a 12 year period is presented. More detailed analysis will yield much additional information of special value. The most common tumors in the female, among whom cancers predominate, are those of the breast and uterus followed by those of the digestive tract. In men the last mentioned are the most common neoplasms. Cancer of the stomach, however, appears to have an unusually low incidence in Connecticut. The chances of surviving 5 years after a diagnosis of cancer is established in Connecticut are roughly 1 in 4 in the population as a whole. They are better in women than in men. The diagnostic attack should be centered on the age groups lower than those suggested by the peaks of age incidence.

THE TREATMENT OF NEUROSYPHILIS

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SYPHILIS is still one of the most important infectious diseases in our society both in frequency and in gravity. The serious nature of this disease derives more from its frequent involvement of the nervous and the cardiovascular systems than from such relatively benign or uncommon complications as tertiary lesions of the skin and bones, gumma of the liver, gastric syphilis and others. Neurosyphilis, which so often threatens life or results in economic dependence, is the outstanding complication of syphilis and accounts for 5 to 10 per cent of the admissions to psychopathic hospitals and an equal number of admissions to neurological wards.[1,2]

Despite great advances in the field of therapeutics during the past decade syphilis is often treated inadequately. This defection does not arise from a lack of effective methods of treatment because the medical profession has possessed the means of preventing neurosyphilis and cardiovascular syphilis for many years, even before the discovery of penicillin. The difficulty has been (a) to find the cases before irremediable damage to the aorta and nervous system have occurred and (b) to administer prompt and effective treatment. The first of these can be overcome by educating the public as to the necessity of periodic blood tests on every person in the community and the second by keeping the medical profession well instructed in the proper methods of diagnosis and treatment of this disease. These medical and sociological obstacles that have prevented the almost complete eradication of neurosyphilis should be kept clearly in mind during the present period of excitement over the therapeutic accomplishments of penicillin.

If the contention that neurosyphilis is the mos important complication of syphilis be accepted, the it behooves every physician to obtain some familiar ity with the basic facts regarding the biology of th neurosyphilitic infection. Without a knowledge o these facts it is not possible to treat patients witl syphilis intelligently. The writer believes that th following principles are reasonably well establishe by clinical and by postmortem observation and serv as practical guides in the diagnosis and treatment o neurosyphilis.

(1) *The treponeme usually invades the centra nervous system within the first 3 to 18 months o the infection.* If the nervous system is not involve by the end of the 2nd year, as shown by a complete ly negative cerebrospinal fluid, there is less than a 5 per cent chance that the patient will subsequently develop neurosyphilis; if the nervous system is not affected by the 5th year, there is less than a 1 pe cent chance of neurosyphilis developing at some future time.

(2) *The initial event in the neurosyphilitic infection is a meningitis which occurs in about 25 per cent of all the cases of syphilis.* Usually this meningitis is asymptomatic and can be discovered only by lumbar puncture; exceptionally, it is more intense and causes cranial nerve palsies, convulsions, apoplectic phenomena (due to associated vascular lesions), and symptoms of increased intracranial pressure.

(3) *If untreated this meningitis may persist in an asymptomatic state and ultimately, after a period of years, cause parenchymal damage.* In some cases, however, there may be a natural subsidence of the meningitis, a spontaneous cure.

(4) *All forms of neurosyphilis begin as a meningitis and a more or less active meningeal inflammation is the invariable accompaniment of all forms of neurosyphilis.* The early clinical syndromes are meningitis and meningovascular syphilis; the late ones, general paresis, tabes dorsalis, vascular syphilis,

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optic atrophy, meningomyelitis, etc., are pathological sequences which result from chronic syphilitic meningitis. The intermediate pathologic stages in the transformation of asymptomatic syphilitic meningitis to the late forms of parenchymatous neurosyphilis are unknown. Since syphilis is the only common example of chronic meningitis which is known to affect man, many of the pathological changes thought to be peculiar to syphilis of the nervous system are, at least in part, due to this chronicity of the meningeal reaction. Confirmation of this hypothesis can be obtained by a study of the brain and spinal cord in the more chronic cases of bacterial and torula meningitis; arteritis and thrombosis of subarchnoid arteries, meningoencephalitis, ependymitis and meningomyelitis, resembling in many respects the lesions in neurosyphilis, can be found in some of these diseases. The treponeme rarely if ever affects the peripheral nervous system.

(5) *Asymptomatic neurosyphilis is, from the therapeutic aspect, the most important form of neurosyphilis and can be diagnosed only by the routine examination of the cerebrospinal fluid in all cases of latent syphilis.* If all cases of asymptomatic neurosyphilis were discovered and adequately treated, the symptomatic varities of neurosyphilis could be prevented. The underlying pathologic change consists of either a diffuse or patchy meningitis in most cases, though in a few, other lesions may be combined.

(6) *So called "vascular" syphilis is usually, if not always, meningovascular syphilis.* In all types of meningitis, i.e., bacterial, fungous, treponemal, it is common to find an inflammatory reaction in the walls of subarachnoid arteries. In the more chronic types of meningitis a fibrous thickening of the vessel wall, narrowing of the lumen and thrombosis may occur.

(7) *Clinical syndromes such as syphilitic meningitis, meningovascular syphilis, general paresis, tabes dorsalis, optic atrophy, etc., are abstractions which at autopsy seldom exist in pure form.* More often since all of them have a common origin in a meningitis there is a combination of two or more syndromes, i.e., meningitis and vascular syphilis, taboparesis, etc. Just why the most intense meningeal reaction and consequent parenchymal damage is in the brain in one case and spinal cord in another is not known. In most cases there are diffuse changes in both brain and spinal cord not so as to be clinically detectable, even though the symptoms have been referrable to only one part of the nervous system.

(8) *The cerebrospinal fluid is a sensitive indicator of the presence of active neurosyphilitic infection.* It reflects fairly accurately the presence of meningeal inflammation. When there is a pleocytosis and an increased total protein, infiltration of the pia-arachnoid with lymphocytes and plasma cells will invariably be found at autopsy. However, there may occasionally be a slight to moderate cellular infiltration of the meninges, either diffuse or in multiple foci, in patients whose cerebrospinal fluid contains no cells. In such cases the total protein is usually elevated.

(9) *The abnormalities of the cerebrospinal fluid which are commonly found in neurosyphilis are* (a) cells which number up to 200-300 and include mostly lymphocytes and a few plasma cells and other mononuclear cells, (b) *elevation of protein*, particularly the globulin fraction, from 40 to 200 mg. per 100 cc, (c) an *abnormal colloidal gold curve* which may be first or midzone, (d) *positive complement fixation and precipitin test.* Elevation of the protein and the presence of cells are indicative of meningeal inflammation and a positive Wasserman marks the infection as syphilitic. The earliest changes in the cerebrospinal fluid consist of pleocytosis and an elevation of protein. This may occur in the first few weeks of the infection before the cerebrospinal fluid Wasserman becomes positive. Later the cerebrospinal fluid changes may vary from a very pronounced abnormality in all tests, i.e., increase in cells, elevated protein, first zone gold sol curve and a strongly positive Wasserman, to a fluid with a weakly positive Wasserman, negative colloidal gold test, normal protein and no cells. With either spontaneous or therapeutic remission of the disease the cells disappear, the protein returns to normal, the colloidal gold becomes less abnormal and finally negative. The blood serology is usually positive if there is an abnormal cerebrospinal fluid but exceptions occur; the blood Wasserman may at times be negative even in general paresis.

(10) *The pattern of cerebrospinal fluid abnormality is not diagnostic of the type of neurosyphilis.* In fact many of these changes can occur in non-syphilitic disease, e.g., first zone gold sol curve in multiple sclerosis or brain tumor. Therefore such terms as "paretic" or "tabetic" formula should be abandoned. As a rule the more intense the neurosyphilitic infection the greater is the abnormality

of the cerebrospinal fluid. In general paresis there are, for example, usually 50 to 200 cells, a total protein of 40 to 200 mg. per 100 cc., a first zone colloidal gold curve and a strongly positive Wassermann. These same changes may be found in asymptomatic or occasionally in any type of neurosyphilis.

(11) *The cerebrospinal fluid is an almost infallible guide, probably even more than the clinical symptomatology, in the diagnosis and treatment and prognosis of the disease.* If the cerebrospinal fluid is negative in a case in which there are symptoms of neurosyphilis it may be safely concluded that the syphilitic inflammation in the nervous system is burnt out and that further progression of the disease probably will not occur. In cases with progressive neurological symptoms and a completely negative cerebrospinal fluid, postmortem examination usually reveals a nonsyphilitic neurological disease. If treatment restores the cerebrospinal fluid to normal, particularly the cell count and protein, arrest of the clinical symptoms almost always occurs. A return of cells and protein precedes or accompanies a clinical relapse.

(12) *These same general rules apply to congenital neurosyphilis.*

Recommended Methods of Treating the Different Forms of Neurosyphilis

There are at present three methods of treating neurosyphilis. They are penicillin, artificial hyperpyrexia, and mapharsen and bismuth.

Penicillin is now generally recognized as the most effective of these methods. Although it has not been available long enough for its true value to be fully appreciated, there is little doubt as to its potency in all forms of neurosyphilis. The exact dosage and the frequency with which courses should be repeated are not settled. It is currently believed that between 6,000,000 and 10,000,000 units given in doses of 40,000 to 50,000 units intramuscularly every 3 hours day and night give the most satisfactory results. Less than 2,400,000 is inadequate; the superiority of over 10,000,000 units in a single course is not established. Commercial preparations have in the past contained varying amounts of F, G, K and X types of penicillin. Penicillin G is a quite effective antisyphilitic agent whereas K is of little value in syphilis or other infections as well. Recently manufacturers have taken steps to assure high levels of G. Oral penicillin or intramuscular penicillin in peanut oil and beeswax have not been used in a sufficiently larg number of cases to be recommended to the medic profession at this time. Because of the ease of admir istration and economic saving (hospitalization woul not be required) it is hoped that these methods wi become available.

Fever therapy has been in use for many years an its value is well established. The simplest and mos practical method of inducing fever is by inoculatio of blood containing the parasites of benign tertia malaria. Quartan malaria, intravenous injections o typhoid vaccine, and cabinet fever are alternat methods. For technical details the reader is referre to one of the standard textbooks on the treatmen of syphilis.

Mapharsen and bismuth are still being used i conjunction with penicillin in many clinics. Mapha sen has almost completely replaced arsphenamin and neoarsphenamine and bismuth is preferred t other heavy metals. Tryparsamide has been discarde because of the damaging effect on the optic nerve Mapharsen is given intravenously in doses of 30 to 6 mg. once each week. Some workers favor a shorte interval between injections, i.e., daily or bi-weekly Bismuth is administered intramuscularly in doses o 0.2 gm.; the subsalicylate form is most satisfactory These two drugs may be given simultaneously bu most syphilologists prescribe them singly in course of 10 weekly injections. The total amount of ma pharsen and bismuth which is given varies from on clinic to another. Probably a total of 1800 mg. o mapharsen with a corresponding amount of bismut constitutes a full course.

All of these methods can be used without fear o therapeutic paradox (Herxheimer reaction).

At present the leading syphilologists in the coun try are not in agreement as to whether or no penicillin can completely replace mapharsen an bismuth and fever therapy. There is one group o reliable workers among whom are Stokes[3] and Datt ner[6] who maintain that penicillin if given in adequat dose will control all types of neurosyphilis. Anothe group, which includes Moore,[4] Solomon and Rose, and many others of the Cooperative Clinical Group are more reserved in their judgment and point ou that penicillin either combined with fever therapy or with mapharsen and bismuth is the safest an most reliable method at present. Some of these points will be settled only after many years of careful study. The average physician is not in positio to participate in the investigation of this problem. It

his duty to use the methods which are considered the time to be the most reliable and effective. he following recommendations are made with this mind. The physician must be prepared to modify em in accordance with whatever advances will cur in the next few years.

In the following pages the principal types of urosyphilis, their diagnostic criteria and the best ethods of treatment are described briefly.

ASYMPTOMATIC NEUROSYPHILIS

In this condition there are no symptoms or physi- l signs excepting, in some cases, abnormal pupils. he diagnosis is based entirely on the cerebrospinal uid findings without which the case would be re- arded as latent syphilis, or if other viscera are ffected, cardiovascular, gumma, etc. The abnor- ality in the cerebrospinal fluid varies as mentioned section 10 above.

The recommended treatment is penicillin 6,000,- 00 to 10,000,000 units intramuscularly in doses of ,000 units every 3 hours or 100,000 units every 6 ours day and night. The patient should be re- xamined every 3 months and the cerebrospinal fluid ould be retested after a 6 months interval. If after months the patient is free of symptoms and the erebrospinal fluid is improved, all cells having dis- ppeared, the protein returning to normal, the read- ng in the colloidal gold test and the liters in uantitative Wasserman tests having decreased, no urther treatment is indicated. Further follow-up ould include another clinical examination at 9 and 2 months and another lumbar puncture at the end f a year. Satisfactory progress is judged by absence f symptoms and further improvement in the erebrospinal fluid. These procedures should be re- eated every 6 months until the cerebrospinal fluid ecomes completely negative. In the opinion of any syphilologists a continued weakly positive Wasserman or precipitin test after the cells and rotein levels have returned to normal does not onstitute an indication for further treatment. According to the Dattner-Thomas concept of eurosyphilitc activity such a cerebrospinal fluid ssures that the disease is quiescent or arrested. Other syphilologists are not sure of the reliability f this concept and prefer to give further penicillin nd a course of mapharsen and bismuth for at least year if this type of cerebrospinal fluid abnormality ersists. If at the end of 6 months there are still cells nd elevated protein in the fluid, either another full course of penicillin or this drug in combination with malaria should be given. We have usually advised at this time the combined penicillin-malaria treatment unless there were other medical contraindications.

If the patient cannot enter the hospital for penicillin therapy one or two courses of mapharsen and bismuth can be substituted. Pronounced cerebrospinal fluid abnormalities at the end of a year require the addition of penicillin or penicillin and malaria.

The prognosis for asymptomatic neurosyphilis is excellent if treated in this way. In almost all cases the late forms of neurosyphilis will be prevented. If not treated or inadequately treated a certain proportion of these patients will eventually develop meningovascular syphilis, general paresis, tabes dorsalis, etc.

B. SYPHILITIC MENINGITIS

Symptoms of meningeal involvement may occur at any time after the infection but most often within the first 2 years. The commonest symptoms are cranial nerve palsies, headache, stiff neck, convulsions, mental confusion. Occasionally headache, papilledema, nausea and vomiting occur due to the presence of increased intracranial pressure. The cerebrospinal fluid is always abnormal, often more so than in asymptomatic neurosyphilis. The treatment should be: penicillin 6,000,000-10,000,000 units. Follow-up care and indications for further treatment are the same as in asymptomatic neurosyphilis.

The prognosis is good. The symptoms usually disappear within days to weeks but if the cerebrospinal fluid remains abnormal there is likelihood that some other form of neurosyphilis will subsequently develop.

C. MENINGOVASCULAR SYPHILIS

This diagnosis is tenable when a young person has one or several strokes or cerebrovascular accidents, i.e., a relatively sudden development of paralysis, aphasia, sensory loss, visual disturbance or mental impairment. The commonest time of occurrence of meningovascular syphilis is the 6th or 7th year but it may be as early as 6 months or as late as 10-12 years. The cerebrospinal fluid almost always shows some abnormality, usually increased cells and elevated protein as well as abnormal colloidal gold curve and positive Wasserman. Cases with apoplectic symptoms and a negative cerebrospinal fluid and also some cases in middle or late life with posi-

tive cerebrospinal fluids often will be found at autopsy to have atherosclerosis or a combination of meningovascular syphilis and atherosclerosis.

The treatment should be penicillin 6,000,000-9,000,000 units. If further treatment is necessary another course of penicillin or a course of bismuth and mapharsen as in asymptomatic and meningeal forms of neurosyphilis should be given. If for some reason the patient cannot enter the hospital for penicillin therapy quite satisfactory results can be obtained by one or two courses of mapharsen and bismuth. Fever therapy should be reserved for those who are not too old, are in good physical condition and still have active fluids, i.e., cells and elevated protein despite penicillin, mapharsen and bismuth.

The prognosis as to the prevention of further apoplectic phenomena is good. The residual neurological signs which remain after 6 months will usually be permanent. If repeated cerebrovascular accidents occur despite adequate therapy, one must always keep in mind the possibility of other non-syphilitic vascular diseases of the brain.

D. GENERAL PARESIS (DEMENTIA PARALYTICA, SYPHILITIC MENINGOENCEPHALITIS)

This usually develops after the patient has had neurosyphilis, usually in asymptomatic form for 15 to 17 years. The outstanding symptoms are in the psychiatric sphere and consist of nervousness, change in conduct and a general intellectual deterioration. Convulsive seizures and cerebrovascular accidents are frequent. Pupillary abnormalities, dysarthria, tremors of the tongue, lips and outstretched fingers are often present but in many cases there are no abnormal neurological signs. General paresis must be distinguished from syphilitic meningitis and meningovascular syphilis in which psychoses may also occur. Whenever a middle-aged or elderly person has a seizure, becomes nervous or has for the first time any major psychiatric illness, general paresis should be suspected. The cerebrospinal fluid is always abnormal usually with 10 to 200 lymphocytes, plasma cells and mononuclear cells, a total protein of 40 to 200 mg. per 100 cc., a first zone gold sol curve and Wasserman and Davies-Hinton tests that are positive in very small amounts of fluid.

The best therapeutic results are said to be obtained by a combination of penicillin 6,000,000 units and 10 paroxysms of malarial fever. However, there is now substantial evidence showing that one or more courses of penicillin will control the disease in most instances. The practicing physician who lacks the facilities for conducting malarial fever therapy is probably justified in using only penicillin if opportunity for careful follow-up examinations and lumbar punctures is provided. If the patient is difficult to manage and unreliable, malaria and penicillin should be given at the same time. Mapharsen and bismuth will not control this form of the disease.

After the initial therapy re-examination every 3 months and lumbar puncture every 6 months should be performed. If the cerebrospinal fluid remains quite abnormal with elevation of protein and cells another course of penicillin with or without cabine fever or quartan malaria are needed. If clinical improvement occurs and the cerebrospinal fluid becomes inactive with only a positive Wassermar reaction no further treatment is indicated. Clinical relapse is almost invariably attended by recurrence of cells and increase in protein levels. Rapid clinical progression in the face of a negative cerebrospinal fluid suggests the presence of a non-syphilitic disease of the brain; antisyphilitic therapy in such cases is usually of no value.

The prognosis in early cases is fairly good; 35 to 40 per cent of cases will make some occupational readjustment, and the disease will be arrested but leave the patient economically dependent in another 40 to 50 per cent. Without treatment there is progressive mental enfeeblement and death within 3 to 4 years.

E. TABES DORSALIS (TABETIC NEUROSYPHILIS)

This type of neurosyphilis usually develops 15 to 20 years after the infection begins. The major symptoms are lightning pains, ataxia and urinary incontinence and the chief signs are absent knee or ankle reflexes, impaired vibratory or position sense in feet and legs and a positive Romberg sign. The pupils are abnormal in over 90 per cent of cases, often of Argyll Robertson type. Gastric crises and Charcot joints are less frequent. The cerebrospinal fluid is normal (so called burnt out tabes) when the patient is first examined in 5 to 10 per cent of cases. In the others it is abnormal but often less so than in general paresis.

If the cerebrospinal fluid is negative and there is no evidence of cardiovascular or other type of syphilis, no further antisyphilitic treatment is necessary. If positive, the treatment should be penicillin 6,000,000-10,000,000 units. The patient should be re

examined every 3 months and the cerebrospinal fluid should be retested every 6 months. If there is no further progression of clinical symptoms and the cerebrospinal fluid becomes negative, no further treatment is necessary. If the cerebrospinal fluid is unimproved, containing an increased number of cells and an elevated protein 6 to 12 months after the treatment, another course of penicillin or, even better, penicillin and fever therapy are indicated. Some syphilologists prefer cabinet fever to malaria but if only the latter is available it may be used safely in most cases. If the patient cannot be hospitalized for penicillin or fever treatment, mapharsen and bismuth should be tried in an attempt to render cerebrospinal fluid inactive. Residual symptoms in the form of lightning pains, gastric crises, Charcot joints, or urinary incontinence frequently continue long after all signs of active neurosyphilitic infection have disappeared. These should be treated symptomatically rather than by antisyphilitic drugs.

F. SYPHILITIC OPTIC ATROPHY

The usual symptoms are progressive blindness beginning in one eye and then involving the other. The visual fields are usually constricted but scotomas may occur in some cases. The optic discs are grayish-white. Other forms of neurosyphilis, particularly tabes dorsalis, frequently coexist. The cerebrospinal fluid is almost invariably positive though the degree of abnormality may be slight in some cases. Visual impairment may progress in exceptional cases even after the cerebrospinal fluid becomes negative.

The best treatment is penicillin 6,000,000-10,000,000 units in combination with tertian malaria though, as in general paresis, penicillin alone gives quite good results. The visual fields and visual acuity should be tested every 6 weeks and the cerebrospinal fluid every 6 months. If the symptoms progress after 3 to 6 months further penicillin treatment may be given. As a rule if the cerebrospinal fluid is negative, very little benefit accrues from further treatment. The prognosis is poor if vision in both eyes is greatly reduced. If only one eye is badly affected sight in the other eye can usually be saved.

G. SPINAL SYPHILIS

There are 4 types of spinal syphilis other than tabes. Two of them, syphilitic meningomyelitis sometimes called Erb's lateral sclerosis and spinal meninugovascular syphilis, are not too infrequent though less common than tabes. Gumma of the spinal meninges and cord is rare and syphilitic progressive muscular atrophy or amyotrophic lateral sclerosis is a very rare disease of questionable etiology. In all of these syndromes there is an abnormal cerebrospinal fluid, unless of course the neurosyphilitic infection is burnt out.

The treatment should be penicillin, 6,000,000-10,000,000 units in the usual dosage. If the symptoms continue to progress and the cerebrospinal fluid is still quite abnormal 6 months after treatment, another course of penicillin should be given. The prognosis is usually uncertain. There is improvement or at least an arrest of the disease process in most instances, though a few may progress slightly after the treatment is begun. A steady advance of the disease with a negative cerebrospinal fluid usually means that the original diagnosis was incorrect and that the patient suffers from some other disease, e.g., a spinal form of multiple sclerosis. No further treatment is indicated once the cerebrospinal fluid becomes negative. In cases of syphilitic progressive muscular atrophy or amyotrophic lateral sclerosis with the typical cerebrospinal fluid findings of syphilis it is probably advisable to give penicillin and malarial fever. This disease is usually progressive with death from bulbar paralysis and pneumonia within a few months to years regardless of the type of therapy.

H. SYPHILITIC NERVE DEAFNESS

This may occur in either early or late syphilitic meningitis and may be combined with other syphilitic syndromes. Since the deafness is often progressive some workers advise penicillin and malaria. We have had no experience in the treatment of this disorder.

CONCLUSION

In every case with repeatedly positive blood serology it is necessary to determine (1) whether the patient has neurosyphilis, (2) is so what type it is, and (3) whether or not it is active. This can usually be done by obtaining a careful history, doing a complete physical examination including a rough mental status and tests of visual acuity, visual fields, hearing, the muscular power and coordination of the limbs, the reflexes and sensation. Sometimes in a given case even experts in the field cannot decide what type of neurosyphilis is present. If in doubt as to which of two neurosyphilitic syndromes the patient has, it is wise to treat him as if he had the more serious of the two. For example, if one cannot

decide whether a given patient has asymptomatic neurosyphilis or general paresis, he should be treated for the latter, i.e., penicillin or penicillin and malaria.

Over-treatment with antisyphilitic drugs is economically wasteful and at times harmful. It should be remembered that once the central nervous system has been damaged residual symptoms will usually remain. For example, in tabetic patients the ataxia, lightning pains and urinary incontinence may persist after all signs of active infection have ceased. These symptoms should be treated symptomatically by analgesic drugs, pain-relieving surgery, etc., and not by more penicillin, mapharsen and bismuth. Similar problems arise in connection with other forms of neurosyphilis also necessitating special measures to control symptoms and aid in occupational and social readjustment.

Neurosyphilis can be prevented by the prompt and adequate treatment of primary, secondary and latent syphilis. Once the nervous system has been involved the administration of penicillin, malarial fever and/or mapharsen and bismuth in proper dose will usually arrest the disease.

In order to diagnose neurosyphilis a lumbar pun ture must be done on every patient with syphil A proper evaluation of the cerebrospinal fluid r quires a cell count, measurement of protein, colloid gold test and Wasserman. Without information to the condition of the cerebrospinal fluid it is in possible to diagnose or treat this disease effectivel

BIBLIOGRAPHY

1. Moore, M. and Merritt, H. H.: Role of Syphilis of t Nervous System in the Production of Mental Disea J.A.M.A. 107:1292, 1936.

2. Merritt, H. H. and Moore, M.: The Problem of Syphi on the Wards of a Large General Hospital. New Eng. Med. 219:834, 1938.

3. Stokes, J. H.: Penicillin Alone in Neurosyphil J.A.M.A. 131:1, 1946.

4. Moore, J. E.: Penicillin in Syphilis. Charles C. Thom Publ., 1946.

5. Rose, A. S., Trevett, L. D., Hindle, J. A., Prout, Sol mon, H. C.: Penicillin Treatment of Neurosyphilis. A J. Syph. Gonor. and Ven. Dis. 29:487, 1945.

6. Dattner, B.: Value of Penicillin in Treat. of Neur syphilis. Arch. of Neurol. and Psych. 57:270, 1947.

THE MEDICAL PROFESSION'S INTEREST IN INDUSTRIAL MEDICINE AND SAFETY SERVICES

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The picture in industrial medicine in Connecticut has changed considerably in the last thirty years. There were but few industrial plants covered by physicians thirty years ago and medical men were not disposed to approve this branch of medicine. It was classed as contract medicine. In general the caliber of men engaged in industrial medicine was not of high educational standard. Medicine felt that there was great danger that the quality of medicine would be lowered. It felt that inroads would be made on the family practitioner and that the injection of a third party would destroy the physician-patient relationship, also that competitive bidding for services would be harmful to patient, physician, and industry.

At that time industry itself did not have a hig regard for the industrial physician or for industri medicine. It felt that the industrial physician was meddler. The old time industrialist looked upon th industrial physician as an intruder. He believed tha the industrial physician did not know anythin about industry, its problems, or its plants. A gre change has come into being about this type c practice. Here in Connecticut some of our be physicians are engaged in this work. Some are o full time, some part time, and some are coverin several small plants. They are doing a needed an useful work. Workmen are given careful physic examinations. In some plants frequent chest x-ray are taken. Absenteeism is being reduced. Contagiou

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id infectious diseases are more readily controlled. When indicated, workmen are sent to their family physician for the care of all diseases, including the important degenerative, metabolic, and neoplastic seases. In other words, the health of men in industry is being more carefully protected.

The Connecticut State Medical Society approves dustrial medicine and recognizes its importance. he Committee on Industrial Medicine, which is commended by the Council of the State Society or approval by the House of Delegates, is the most tive committee in the State Society.

The importance of the Division of Industrial Medicine in the State Department of Health cannot e overemphasized and Dr. Albert Gray, the director, has a national reputation. His contributions and he contributions of the department are well known. would be impossible to tell the number of lives hat have been saved by the advice and direction iven by him and the Department to industry.

Men of industry and industrial medicine do not ave to be told the story of pneumoconiosis and lied pulmonary lesions. The July 1947 issue of *Occupational Medicine* was dedicated to Dr. Leroy V. Gardner, a native of Connecticut. The thouands of lives that have been saved and will be saved the future is an everlasting monument to his ork in industrial medicine. Here in Connecticut e are very proud of him.

Greater stress must be placed on the importance f teaching industrial medicine in our medical chools. President Alan Valentine of the University f Rochester, in an address in Chicago in February t the meeting of the Congress on Medical Education and Hospitals, said that there were not more han three universities in America with good industrial medical departments. This must and will be orrected.

During the past few years close cooperation has eveloped between Yale University School of Medicine and the Connecticut State Medical Society. This is as it should be. During this time the medical chool has started a division of industrial medicine. The Connecticut State Medical Society is proud of s participation in this development. It is important hat young men who are to do this work in the uture should be properly trained. The industrial physician of the future in Connecticut will be in a ighly specialized field and must obtain and be given pecialized training. Dr. R. F. Buchan, who is in harge of this work at Yale, is a member of the Committee on Industrial Medicine of the Connecticut State Medical Society. Two refresher courses on industrial medicine have been given at the medical school during the past few years. This activity is important in order that the medical men in industry and those in general practice who do part time industrial work will be able to guarantee workmen the best possible medical care.

We look forward to the day here in Connecticut when our larger hospitals will have services devoted entirely to industrial medicine. And why not? It is a big and active and selective specialty. The problems frequently are unique and differ from the many other problems in a general hospital. We can predict that the nursing profession will make a real contribution to industrial medicine. This is a branch of nursing that requires unusual balance and judgment as well as skillful nursing and kindness. An article in the May issue of the *American Journal of Nursing*, states "In no field of nursing are integrity, sound judgment, and professional maturity more strongly challenged than in industrial medicine." Special training must be provided for nurses in this highly specialized field.

The Connecticut Safety Council is in the same position that we in medicine place departments of health. Their functions are similar. The health departments attempt to prevent all illnesses. The Safety Council is dedicated to the prevention of accidents. It is a noble marriage.

Research must continue. The proper place for this work in Connecticut is in the Industrial Division of Yale University School of Medicine. This is expensive and requires large endowments, and this is a duty of Connecticut industry. I am sure that the industry of now and the future will accept this responsibility, for it will pay large dividends.

Connecticut was one of the first states, if not the first, to provide employment for the physically handicapped. This was a great step forward and redounds to the credit of Connecticut industry, safety, and medicine.

There is another and new phase of work to which we must all contribute. I refer to rehabilitation. The work of Dr. Howard Rusk has made us all conscious of our laxity and weakness. Again industry, nursing, and medicine must join hands in the great endeavor to help people help themselves.

It is proper to discuss some phases of the work of the Manufacturers Association of Connecticut. This association has come hand in hand with the other

groups in the advancement of industrial medicine. The advances in the last quarter of a century have been tremendous. We must not stop here. A great attack is being made on voluntary medicine in the United States. Some of the proponents of federal medicine are undoubtedly sincere, if misguided. Some are not. Some are followers of ideologies that are foreign born and that are persistent in their efforts to destroy a free America. They must not be permitted to succeed. If this happens the free and voluntary, and great institutions that we have known must fall. Following this, and as sure as night follows day, transportation, insurance, heavy industries, and utilities will come into their hands. The time has come for industry to realize that, if medicine as we know it goes down, it is the beginning of a day in America that will be black indeed. We should not be fooled by the assertions of these people that they are interested in the common m It is foolish to believe that the federalization medicine would give more or better care to e sick. No one in Connecticut is being denied exc lent medical care at any time. Medical men e proud of their heritage. They know and are will g to accept the responsibility of caring for the si and at any and all times. Industry does not w this interference; the Safety Council does not w it; medicine does not want it. Let us have less a less of subsidies and interference from the fed government and more and more of volunt agencies.

With the generous cooperation of Connecti industry, the Safety Council, and industrial me cine the top rung of the ladder can be reached a maintained. The Connecticut State Medical Soci assures you of its unalloyed support.

MEDICAL TREATMENT OF THYROID DISEASE

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A great deal has been written on the medical treatment of thyroid disease. The greater part of this work has been done by Astwood and Vanderlaan of Boston and Crile of Cleveland. A review of this work and a review of a small series of cases treated at the New Britain General Hospital offers hope that some day medicine may supplant surgery in the treatment of thyroid disease. The use of drugs in this disease requires a knowledge of the physiology of the thyroid gland. The gland is one of internal secretion and has a hormone which is the regulator of body metabolism. It is one of a chain of endocrine glands which seem to have an interdependence among them; an abnormal stimulation of one of the glands seems to effect one or a number of glands in the chain. The exact mechanism of the production of the hormone is not thoroughly understood. However, it has been shown rather conclusively that inorganic iodine is absorbed by the thyroid gland and here it is converted to an organic iodine, diiodotyrosine, by combining with the essential amino acid, tyrosine. By an oxidative or enzymatic process, thyroxin the hormone s formed. Some biochemists carry this a bit furth and, by combining the latter with another ami acid, thyroglobulin is formed. At any rate, a d turbance in the production of this hormone resu in the clinical syndrome of toxic thyroid on the e extreme and myxedema on the other. A modifi tion of either extreme lies in the quantitative p duction of the hormone.

The syndrome of toxic thyroid is produced by abnormal emotional shock. The primary seat of t initial stimulus has not been established. It may the adrenals. However, the stimulus is conduct along the sympathetic chain of the autonomic ne ous system and reaches the hypothalamus. Thence is directed to the anterior lobe of the pituita here the thyrotropic hormone is stimulated, whi in turn stimulates the thyroid hormone. Accordi to Palmer, in the normal thyroid equilibrium established between the thyroid hormone and t anterior lobe of pituitary hormone. Also an exop thalmic factor is maintained in equilibrium by t

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tyroid hormone. In exophthalmic goitre or Graves' disease, there is an abnormal stimulation of thyroid hormone so that there is a hypermetabolism of body tissues but there is no neutralization of the thyrotropic hormone or its exophthalmic factor. This sequence, though theoretical, nevertheless explains in part the syndrome of Graves' disease.

A comparison of the medical treatment of hyperthyroidism with the surgical treatment shows that the same end can be accomplished with either method. The newer drugs, i.e., Thiourea, Thiobarbital, Thiouracil, Propylthiouracil, and Methylpropylthiouracil cause a physiological ablation of the thyroid gland. Surgery is an anatomical removal of excess and abnormal thyroid tissue. These drugs allow the assimilation of inorganic iodine into the thyroid gland but prevent its synthesis to organic iodine and thyroid hormone. In view of this, a review of the pathology of hyperthyroidism stimulated enthusiasm for the use of drugs in this disease. The normal thyroid gland consists of a number of acini lined by low cuboidal epithelium and containing colloid. A series of changes take place depending upon the amount of toxicity. First there is a hyperplasia of the gland with a conversion of the cuboidal epithelium to tall columnar epithelium and a decrease in the amount of colloid. This stage is that of mild hyperthyroidism. Next we get the above changes plus hypertrophy of the gland. The first stage, left untreated, may involute and return to normal. The second stage by a number of exacerbations and remissions may go beyond the stage of normalcy; it may even, in rare instances, approach myxedema. It is this gland which shows a great deal of scar tissue surrounding the acini. Thus we see that a toxic gland will eventually burn itself out if left untreated. However, we know this is not the answer. During this long period of exacerbations and remissions we must avoid the ravages of toxicity. It is here that our antithyroid drugs have their place. If the drug is given during the periods of exacerbations, it seems that eventually a cure could be accomplished.

At this point I might compare the role of iodine with that of the goitregenic or antithyroid drugs in bringing about a remission. Iodine has both an involuting and iodinating action. The former causes involution of the hyperplastic gland; the latter is used in the production of the thyroid hormone. The complications of surgery with the use of this drug are well known to us; thyroid crisis is a dreaded complication. The use of Propylthiouracil and other drugs has abolished this. By its use, it spends the thyroid of practically all of its hormone so that surgery has been facilitated. In conjunction with iodine to exert its involuting action, the extremely difficult hyperplastic, hemorrhagic, friable gland has been eliminated for the surgeon.

Prior to the discovery of the later drugs, Propylthiouracil and Methylpropylthiouracil, the main objection to these drugs was their toxicity, i.e., agranulocytosis. A series of 500 cases published by Crile and 100 cases by Astwood revealed that not a single fatality was encountered. Because of the toxicity of the earlier drugs, a number of failures were reported in the medical management of toxic thyroid. However, this was due to the fact that the drugs were not used for a sufficiently long period. These failures might be compared to the early days of surgery when recurrences ran as high as 17 per cent. This was probably due to insufficient removal of the thyroid gland at operation. Lasting remissions or even cures seem to vary according to the duration of use of the drug. These drugs have been said to be carcinogenic. Purves fed rats these drugs for one year and found no evidence of carcinoma but did find adenomata in some of his animals. Allen Graham has reported finding, in rare cases, a tumor which he has termed carcinoid. This same rare tumor has been found in other glands removed for other reasons so that it is doubtful if the drugs were instrumental in their causation.

The drug has no place in adenoma of the thyroid, toxic or non toxic. These tumors are prone to malignant changes and because they are circumscribed, surgery is the treatment of choice. However, in diffuse hyperthyroidism the entire gland has been stimulated to hyperplasia, hypertrophy and hyperfunction, so that subtotal thyroidectomy does not seem to remove in entirety the abnormal factors involved. It would seem that total thyroidectomy would more nearly approach the desired end.

In the use of the drug, an increase in the size of the gland and sometimes in exophthalmos is noted. Because of the suppression of thyroid hormone production, the anterior lobe of pituitary thyrotropic hormone causes an abnormal hyperplasia of the gland and an increase in exophthalmos. This can be controlled by giving Thyroxin gr. 1/60 t.i.d., in conjunction with the antithyroid drug.

In favor of the medical treatment of hyperthyroidism over the surgical treatment, a number of

observations have been made. By an adjustment of the dose, the basal metabolic rate can be maintained at almost any desired level. Here the thyroid patient may be compared to the diabetic patient. In either case the dose must be adjusted to the severity of the disease. No refractory cases have been reported. The drug may be repeated any number of times. During the course of treatment patients go astray. These patients can be given the drug repeatedly with a good response. Though the drug is still in its infancy, the lasting remissions to date compare favorably with those accomplished surgically. Next, the technical complications of surgery are still present; the tetany due to parathyroid excision; injury to the recurrent laryngeal nerve; myxedema, and, finally thyroid crisis. Finally, medical treatment can be done more economically because the patient can be ambulatory. The *sine qua non* is the cooperation of the patient. If the pitfalls of the treatment and the close supervision required by the physician are explained to the patient, the percentage of lasting remissions will be higher.

A discussion of the dosage of the drug, Propylthiouracil, is in order. Because of the toxicity of the earlier drugs, i.e., Thiourea, Thiobarbital, Thiouracil, the dose was necessarily small. At the advent of this drug the recommended daily dose was 50-75 mgms. per day. Because of its superior potency over Thiouracil, this very small dose was recommended. However, with more knowledge regarding the drug, and the lack of toxicity, the dose used today is much higher depending upon the severity of the thyroid toxicity; doses up to 400-500 mgms. per day can be used in certain cases. The dose has to be adjusted according to clinical and laboratory response. Usually adjustment according to clinical response is sufficient. Basal metabolism tests need not be done more than once monthly. The patient should be maintained in good clinical health and a metabolic rate of 0 or less on a maintenance dose; this again varies between 25 mgms. to 100 mgms. daily. This should be continued for at least 6 months after good health is established. Though toxic effects have not been encountered in my experience, nevertheless I check the white blood count every 2 weeks during the early stages and then once monthly. Another side effect which has been reported but which I have not encountered is enlargement of the thyroid gland.

In view of the physiology and pathology of thyroid disease there are certain indications for the medical treatment of thyrotoxicosis. This opin has support in the work being done on the use radioactive iodine in the treatment of thyr disease. The fact that the thyroid gland has an alm exclusive affinity for iodine makes it seem possi that radioactive iodine may even supplant the ab goitrogenic drugs. However, regardless of the d used, the indications are the same. Any person w refuses surgery should be given a trial on medici Let us compare the thyroid patient to one who h a peptic ulcer. We are agreed that all ulcer patie should have a thorough medical trial before bei subjected to surgery. The case of mild hyp thyroidism should not be considered surgical at This case must only be maintained on Propylt ouracil until a permanent remission is accomplish Poor surgical risks, i.e., the old, emaciated patie with auricular fibrillation and cardiac failure, mig best be treated medically. Also there may be t case of the pregnant mother who develops thyr toxicosis during pregnancy. Astwood has treat 8-10 pregnant mothers with toxic thyroid wi Propylthiouracil. The results have been good a in no case was the child myxedematous.

Finally, a word about the psychogenic factor all cases of hyperthyroidism. This I can best illu trate by the case of a 26 year old female with seve thyrotoxicosis with all the cardinal signs and sym toms present. Her difficulty started as a result marked domestic difficulties. Her initial bas metabolism rate was plus 54 per cent; this w repeated. She was admitted to the New Brita General Hospital where she was placed on 2 mgms. of Propylthiouracil daily in divided dos Over a period of 3 weeks she gained weight, tremo improved, exophthalmos receded, and, her bas metabolism rate was minus 13 per cent on discharg Against advice she returned home to the san domestic situation. In 3 weeks her basal metabolis rate was up to plus 47 per cent in spite of a dai maintenance dose of 100 mgms. Of course there w an exacerbation of her clinical signs and symptom This type of case is not suitable for a medic regimen. This patient is now being prepared f surgical removal of the thyroid. Certainly, if th initiating factor was sufficiently strong to distur an endocrinological equilibrium, then, if it co tinues to be present, it will surely prevent a lastin remission or even a cure. It seems as though in th situation we would be pouring water on the fi on one side and fuel on the other.

BIBLIOGRAPHY

twood, E. B.: Chemotherapy of Hyperthyroidism; Har- Lectures, Series XL; 1944-1945.

twood, Bissell and Hughes: Studies on Chemical Nature Compounds which Inhibit Function of Thyroid Gland; docrinology, 37:456-481, 1945.

twood & Vanderlaan: Thiouracil Derivatives of Greater tivity for Treatment of Hyperthyroidism; J. C. Endo- nology, 5:424-430, 1945.

twood & Vanderlaan: Treatment of Hyperthyroidism th Propylthiouracil; An. Int. Med. 25, 1946.

rtels: Thiouracil and Allied Drugs in Hyperthyroidism; E. J. Med. 238:6, 1948.

ile, G., Jr.: Treatment of Hyperthyroidism; Can. Med. sn. J., 57:359-363, 1947.

ile, G., Jr.: Treatment of Hyperthyroidism; Mich. State ed. Assn. J., 46:437-440, 1947.

ile, G., Jr., Dinsmore, R. S.: Present Status of Surgical Treatment of Hyperthyroidism, Cleveland Clin. Quart., 13:50, 1946.

Eisenmenger & Steele: Leukopenia Following Use of Propylthiouracil; J.A.M.A., 135:516, 1947.

Lahey, F. H.: Surgery of the Thyroid Gland, N. E. J. Med., 236:26, 1947.

McCullagh, Ryan, Schneider: Propylthiouracil in Treatment of Hyperthyroidism; Cleveland Clin. Quart., 13:232, 1946.

Rogers, Asper, Williams: Clinical Significance of Malignant Neoplasms of the Thyroid Gland; N. E. J. Med, 237:569, 1947.

Stanley & Astwood: Determination of Relative Activities of Anti-Thyroid Compounds in War, using radioactive Iodine; Endocrinology, 41:66-84, 1947.

Vanderlaan and Bissel: Effects of Propythiouracil and Potassium Thyocyanate on the uptake of Iodine by Thyroid Gland in Rate: Endocrinology, 39:157-160, 1946.

DANGERS OF ARTIFICIAL HYPERPYREXIA

Report of a Serious Reaction from Intravenous Injection of Typhoid Vaccine

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ARTIFICIAL hyperpyrexia produced by the intravenous injection of typhoid vaccine enjoys ide use throughout the various phases of medical ractice. It has been applied in chronic inflammatory iseases or those of obscure etiology which have iled to respond to other therapeutic means. Among ie diseases in which typhoid vaccine has been emloyed are: various inflammatory diseases of the ye, thrombo-angiitis obliterans, chronic rheumaoid arthritis, Sydenham's chorea, multiple sclerosis, cute encephalitis; in the past neurosyphilis and iore recently early syphilis, in combination with enicillin and the heavy metals, chronic inflammaory pelvic disease, ulcerative colitis; and in such ermatologic disorders as psoriasis, atopic dermatitis disseminate neurodermatitis), mycosis fungoides, arapsoriasis, chronic lichenoid discoid exudative ermatosis (Sulzberger-Garbe Syndrome) and exoliative dermatitides.

A comprehensive description of the usual reaction duced by intravenous typhoid vaccine has been made by Hench[1] and need not be repeated here. Suffice it to say, the patient experiences a chill, exhibits varying degrees of fever and complains of some of the usual symptoms accompanying hyperpyrexia, such as headache, malaise, nausea, vomiting, diarrhea and backache.

Severe reactions to treatment with typhoid vaccine are rare. However, they do occur and occasionally result in a fatality. On rare occasions, a hypersensitivity to the vaccine may be produced and the patient thrown into a severe systemic reaction on reinjection.[2,3] Allen and Smithwick[4] reported femoral and popliteal thromboses requiring amputation in two patients. Reactivation of latent infections, such as tuberculosis, acute and subacute appendicitis, cholecystitis, enteritis, pneumonitis, pleurisy, nephritis and endocarditis have been noted. Delirium tremens may be precipitated in the chronic alcoholic. Coronary occlusion, cardiac decompensation, as well as enlargement of the heart have been reported.[1,5]

rom the New York Skin and Cancer Unit, Department of Dermatology and Syphilology (Director, Dr. Marion B lzberger), New York Post Graduate Medical School and Hospital

Typhoid vaccine should be used only after careful study and evaluation of the patient's physical status. In patients with known arteriosclerosis, cardiac or renal disease, it should be withheld. It is contraindicated in infections of long standing, in tuberculosis and in acute rheumatic fever. Its use is hazardous in patients in whom hemorrhage may be precipitated, as in those with hemorrhagic diatheses, bleeding ulcers and recent operations. The vaccine should not be administered to individuals with marked emotional or vasomotor instability, as occur in psychotic states, hyperthyroidism and allergic states. Pregnancy, chronic alcoholism, debility and cachexia are further contraindications.

Within reasonable ranges, the dosage of typhoid vaccine does not appear to be a major factor in determining the incidence of untoward reactions. Severe and fatal complications have followed the administration of minute doses, while large ones have been used without incident. The vaccine used by the New York Skin and Cancer Unit and on the Dermatological Services of the New York Post-Graduate Hospital is prepared by the New York City Department of Health. It contains 1,000,000,000 *Eberthella typhi*, 750,000,000 *Salmonella paratyphi* and 750,000,000 *Salmonella schotmuelleri*, or a total dosage of 2,500,000,000 microorganisms per cubic centimeter. The initial dose is 0.1 cc. or 250 million microorganisms; it is given in the morning on an empty stomach and food and fluids are withheld until the temperature reaches its peak. Temperature, pulse and respirations are recorded hourly until the temperature is normal. If the rise exceeds 105 degrees Fahrenheit, it is interrupted by forcing the intake of fluids, administration of aspirin and the application of cold packs. If the preceding bout of hyperpyrexia has been well tolerated, the injection is repeated every third day with increments in dosage made according to the patient's tolerance. If the temperature rises to 105 degrees Fahrenheit, the same dose is repeated; if it reaches 103 to 104 degrees Fahrenheit, the dose is increased by 0.05 cc.; if the rise does not exceed 102 degrees Fahrenheit, the dose is doubled. The course of treatment usually consists of four to six injections.

CASE REPORT

H. H., a 27 year old white male, was admitted to the New York Skin and Cancer Unit of the New York Post-Graduate Medical School Hospital August 12, 1946 with a history of a skin eruption of three months' duration. Three months prior to admission the cubital fossae began to itch, and after scratching, these areas became red and remained so. In five to seven days, red "blotches" appeared on the face an neck, shoulders, trunk and extremities. About one mont prior to admission the patient began to lose his hair an bald spots appeared over his scalp. The remainder of th history is not pertinent.

Physical examination revealed a thin, wiry, young whit male, not acutely ill. Examination of the head and nec showed no abnormalities except for the presence of an upp denture, a few carious teeth in the lower jaw and smal shotty posterior cervical nodes bilaterally. Heart, lung abdomen, extremities and genitalia were normal. The bloo pressure was 136/80.

The skin showed numerous erythematous and somewha scaly plaques varying in size from 1.5 to 8.0 centimeters i diameter. They were distributed over the face, neck, ex tremities and trunk. They were slightly raised and infil trated; some were discrete and others were confluent, espe cially those on the arms and back. The erythema was mor marked in the lesions of the face, neck, shoulders and arms On the lower trunk they were pale pink in color. There wa a patchy alopecia of the scalp involving the vertex, tempora and occipital areas. The lateral two-thirds of the left eye brow was absent and the pubic hair showed considerabl thinning.

Repeated examinations of the urine showed no abnorma findings. Blood count showed 5.4 million erythrocytes, 1 gms. hemoglobin, 9,100 leukocytes, with a differential coun of 73 per cent polymorphonuclears, 1 per cent eosinophiles 19 per cent lymphocytes and 7 per cent monocytes. Comple ment fixation and Kahn precipitation tests were negative Sedimentation rate (Westergren) was 21 millimeters in on hour. The Mantoux reaction was 2 plus with a 1:10,00 dilution of Old Tuberculin and 2 plus (1 plus) with th 1:5,000 dilution. Roentgenograms of the chest revealed relatively small heart and moderate puerile hilar and roo branch thickening. Biopsies of the skin were performed o 4 different sites on 4 different occasions. Two lesions were reported as chronic lichenoid discoid exudative dermatosis of Sulzberger and Garbe, and two as possible early lympho blastoma, the histological picture being by no means classi cal. Biopsy of an axillary lymph node revealed dermato phatic lymphadenitis. Smears from the sternal marrow were normal. Examination of the scalp and pubis under th Wood's light gave negative findings for fungi. Culture o scrapings from these areas showed no growth on Sabour aud's medium. Direct examination of the scrapings wa negative.

On September 11, 1946 a course of x-ray therapy was begun, which was completed on October 11, 1946. The patient received 75r unfiltered to all affected areas except the scalp, for a total dose of 100r.

On September 13, 1946 the patient was given 0.1 cc. o typhoid-paratyphoid vaccine (250 million microorganisms) intravenously. This produced a hard chill, severe headache emesis of dark green fluid and several watery stools. The temperature reached a peak of 104.4 degrees F. three hours following the injection and returned to normal by the next morning. There was little change in the skin lesions.

On October 4, 1946, 0.15 cc. of the vaccine was injected. The temperature rose to 105 degrees F. and returned to normal without incident. On October 25, the patient received

25 cc. of the vaccine at 9:00 A. M.; one hour later he gan to complain of chilly sensations and pain in the domen. There were three watery stools. At 1:00 P. M. the ight of the temperature was reached (103 degrees F.). t 3:00 P. M. the patient felt much improved; the tempera- ire was 100 degrees F. at this time. At 6:00 P. M. the pulse as weak and rapid, the lips and nail beds were cyanotic; ie patient was restless and dyspneic. The *blood pressure* as *70/40*. The patient was given caffeine sodium benzoate tramuscularly, 50 cc. of 50 per cent glucose intravenously, llowed by an infusion of 1,000 cc. of 10 per cent glucose in line and 50 milligrams of neosynephrine in an additional 000 cc. of 5 per cent glucose in saline. This caused the *lood pressure* to rise to *95/65*.

However, at 3:00 A. M. on October 26 the patient's condi- on again deteriorated; the temperature was 100.4 degrees ., the *blood pressure 40/0*, the pulse imperceptible and the atient quiet. 1 cc. of adrenal cortex extract was given intra- uscularly and 1 cc. was added to the infusion which had een started previously. At 4:45 A. M. an infusion of 250 c. of plasma was begun, and this was followed by an addi- onal 750 cc. at 6:00 A. M. The *blood pressure* at this time as *65/50*. The patient's condition remained unchanged until bout 9:00 A. M., at which time the *blood pressure* was *58/40*, ie breathing dyspneic, the pulse 108, regular but weak, and ie heart sounds poor and indistinctly audible. He was pidly digitalized with Digitalene Nativelle and maintained n a dose of 0.2 milligrams daily. During the day of the 7th, the patient received 3,000 cc. of 5 per cent glucose in aline intravenously, 5.0 cc. of adrenal cortex extract sub- utaneously morning and night, 5.0 milligrams of desoxy- orticosterone in oil intramuscularly and 1.0 gm. of sodium hloride three times a day by mouth. This same therapy vas repeated the following day, but the infusion was re- uced to 1,500 cc. On this regime the patient improved con- iderably, with the *blood pressure* varying between *108/72* nd *118/94*. All medication was discontinued on October 28, 946 with the blood pressure remaining constant and the atient feeling well.

COMMENT

Hyperpyrexia produced through the intravenous njection of typhoid vaccine has held a well deserved lace in the treatment of a variety of diseases, and till continues to be useful. Although unfavorable eactions are relatively rare, they may occasionally be severe enough to be a serious threat to the patient. It is to emphasize this point that this case is presented. It is advisable that all patients receiving intravenous typhoid vaccine therapy be hospitalized so that any untoward reactions may be recognized and treated promptly. All patients should be studied adequately to discover any existing pathological state which would contraindicate the use of typhoid vaccine or which might themselves be adversely affected by its administration.

CONCLUSIONS

1. Some of the indications, contraindications and complications of intravenous typhoid vaccine therapy are mentioned.

2. A case of an unusual and unusually severe systemic reaction is reported.

3. Recovery in this case was complete and may have been aided by the prompt institution of adequate therapy for the shock-like and hypotensive reaction.

BIBLIOGRAPHY

1. Hench, S. Philip: Usual and Unusual Reactions to Protein (Fever) Therapy. Arch. Int. Med., 49:1 (January), 1932.

2. Love, J., and Driscoll, H. R.: Anaphylactoid (Sanarelli-Shwartzman) Reaction Following Therapeutic Anti-typhoid Injections. U. S. Naval Medical Bulletin. 45:1104-1109, 1945.

3. Urbach, E., Goldburgh, L. H., and Gottlieb, M. P.: General Sanarelli-Shwartzman Phenomenon with Fatal Outcome Following Typhoid Vaccine Therapy. Ann. Int. Med. 20:989-993, 1944.

4. Allen, A. W., and Smithwick, R. H.: Thromboses of Peripheral Arteries Following Intravenous Injection of Typhoid Vaccine. Report of Two Cases. New England J. Med., 200:217 (January 31), 1929.

5. Ween, H. S., and Hyman, A.: Cardiac Enlargement in Fever Therapy Induced by Intravenous Injection of Typhoid Vaccine. Arch. Int. Med., 77:307, March, 1946.

6. Cecil, L. R.: Non-Specific Protein Therapy. J.A.M.A., 105:1846-1854, (December 7), 1935.

LEIOMYOSARCOMA OF THE RECTUM: REPORT OF A CASE

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Leiomyosarcoma (myosarcoma) of the large bowel is an exceedingly rare lesion. It is surpassed in frequency by the other sarcomata occurring in this area—fibrosarcoma, lymphosarcoma of various types, melanosarcoma (malignant melanoma), and angiosarcoma—which are themselves quite uncommon.[1] In 1920 Lapeyre,[2] after an exhaustive survey of the literature, was able to collect a total of 30 cases of primary sarcoma of the rectum. Of these only 2 were of smooth muscle origin. Rankin and Larson[2] reported four cases of rectal leiomyosarcoma in 1932—the single largest series recorded. These four cases included two previously reported. Since that time Bacon and Scheffler[3] have added one case.

We have recently had the opportunity to observe a case of leiomyosarcoma of the rectum. Since it is such an infrequent tumor, we feel that it should be reported.

REPORT OF A CASE

R. R., a 49 year old Italian male, was admitted to the Hartford Hospital complaining of progressively increasing constipation of 3 months duration. Headache, dizziness, and sweating with sacral and suprapubic cramps on attempting to defecate as well as a moderate distension had been noted. There had been no abdominal pain or vomiting. Stools were described as dark brown with occasional streaking of bright red blood. The appetite had been unimpaired and the weight maintained. Past history and system review were non-contributory.

Physical examination showed a well-nourished stocky individual whose vital signs and blood pressure were within normal limits. Positive findings were limited to the abdomen and rectum. The former was moderately distended and tympanitic without any evidence of spasm, masses or tenderness. The latter revealed several internal hemorrhoids and an irregular egg-sized mass almost completely occluding the lumen. This growth was firmly attached by a broad base to the left anterior rectal wall and prevented palpation of the prostate. It was apparently covered with normal mucosa and its consistency varied from firm to semifluctuant.

Laboratory Data: Hemoglobin 14.5 gms., hematocrit 47.5; WBC 19,200 with 88 per cent polymorphonuclear leukocytes, 8 per cent lymphocytes, and 4 per cent monocytes. Serum protein, acid phosphatase, blood sugar, non-protein nitrogen, and urinalysis were within normal limits. A metastatic x-ray series was negative. Cystoscopy and x-rays of the urinary tract showed no evidence of pressure on the bladder, trigone or ureters from the clinically observed mass.

Following these studies, the anus was dilated under spinal anesthesia and the previous findings confirmed. In addition the center of the mass now presented a depressed area and a draining sinus that had not been previously noted. The tumor appeared to be firmly adherent to the prostate. Biopsy was performed; microscopic examination revealed a tumor made up of interlacing bundles of fusiform cells having oval vesicular nuclei and a moderate amount of cytoplasm. The cells were fairly uniform in their staining and showed occasional mitoses. In some regions the anaplasia was more marked and here greater numbers of mitotic figures were seen. There were many areas of necrosis, particularly in the more superficial portions. There was ulceration of the mucosa with fresh hemorrhage. A Masson trichrome stain showed no evidence of collagen deposition, the tumor cells having a pink appearance except in zones where there had been hemorrhage with reactive fibrosis and scar formation. The histologic appearance of the lesion was that of a leiomyosarcoma of moderate activity, arising probably from the muscularis of the bowel.

After a course of sulfasuxidine, operation was performed under continuous spinal anesthesia. A satisfactory cleavage plane free of tumor was found between prostate and rectum and a combined abdomino-perineal resection was carried out. The patient received 1 transfusion during the operation and left the table in good condition.

Postoperatively there was marked distension relieved by Levine tube. Evisceration occurred through the surgical incision, necessitating a secondary closure. Following this procedure the patient did quite well for a brief interval. However, he began to lose considerable quantities of fluid and undigested food through his colostomy. Approximately 2 weeks after operation he experienced an episode of vascular collapse which was felt by a medical consultant to be the result of pulmonary embolism. The course was one of rapid downhill progress and he died 21 hours after the onset of this vascular episode. Permission for autopsy could not be obtained.

Description of Gross Specimen: The operative specimen consisted of a 27 cm. segment of colon, rectum, anal mucosa and skin. 2 to 3 cm. inside the mucocutaneous junction there was an irregular, roughly spherical mass measuring about 4 x 4 x 4.5 cm. arising from beneath the mucosa

From the Hall Wilson Laboratory, Hartford Hospital, Hartford

d elevating the latter to a height of about 2 cm. Over e midportion of the superior surface the mucosa was cerated and a sinus tract extended about 2 cm. into the pth of the mass. On cross section the tumor consisted firm, slightly rubbery, grayish white, homogeneous tis- e with a partial capsule and scattered irregular zones of morrhage throughout its depth. (Figs. 1 and 2.) The sterior margin of the tumor bulged into the perirectal t and fascia and had a smooth limiting membranous wall

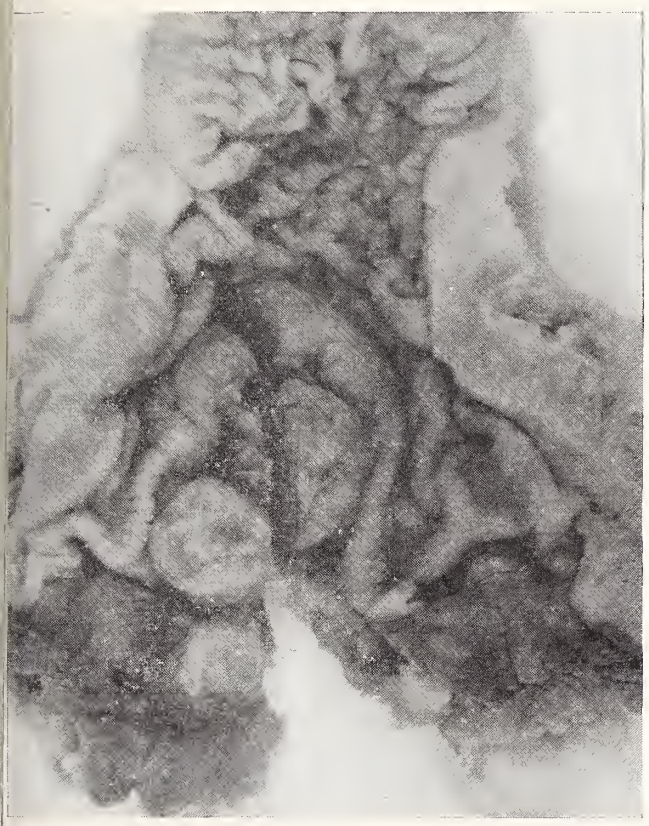


FIGURE 1

Leiomyosarcoma of rectum showing spherical tumor mass just proximal to mucocutaneous margin. Note central ulceration of rectal mucosa

here it had been in apposition with the prostate. On this spect the surgical margin was 2-3 mm. Several small lymph odes in the vicinity of the tumor were not grossly involved y metastasis.

Description of Microscopic Findings: The findings were ssentially the same as those noted on the biopsy described bove. The origin of the tumor from the muscularis was gain strikingly demonstrated. Extension into the submucosa as noted and the ulcerated portions of the mucosa were overed with granulation tissue. Posteriorly the neoplasm as well circumscribed and surrounded by a thin fibrous issue capsule. The lymph nodes showed no evidence of etastatic involvement. The final diagnosis was leiomyo- arcoma of a low grade of malignancy (Figs. 3 and 4).

ISCUSSION

A search of the literature and of the standard edical texts yields a scanty volume of information concerning the frequency and characteristics of leiomyosarcoma of the rectum. The rarity of the tumor is readily discernible from the figures given by Rankin and Graham.[4] Of 542 patients admitted to the section on rectal and colonic surgery at the Mayo Clinic in 1930, 369 (68 per cent) had carcinoma, whereas only one (0.18 per cent) had a sarcoma, a ratio of 369:1. The comparative figures for the stomach are 100:1.[5]

Ewing[5] divides the intestinal sarcomata into three groups:

1. Spindle cell myosarcomata.
2. Lymphosarcomata.
3. Round cell or alveolar sarcomata of uncertain nature.

These are the same types of sarcomata that are described as occurring in the stomach. On the other hand, Bockus[6] classification separates the enteric sarcomata into four subdivisions:



FIGURE 2

Leiomyosarcoma of rectum; cross section view of tumor mass. Note elevation of mucosa and extension through muscular wall

1. Leiomyosarcomata.
2. Fibrosarcomata ("spindle-cell sarcoma") including myxosarcoma.
3. Angiosarcomata.
4. Malignant lymphomata (further subdivided according to the classification of Gall and Mallory[7]).

All authorities agree that the great majority of all intestinal sarcomata are of lymphomatous origin (Ewing,[5] Rankin and Graham,[4] Karsner,[8] and Bockus[6]).

Bockus[6] describes rectal leiomyosarcomata as variable-sized, reddish-gray tumors of rather dense

consistency, composed of smooth muscle cells in a fibrous stroma which may grow into the lumen of the bowel or progress into the pericolic structures. He also states that sarcomata in this region metastasize more rapidly and advance at a faster rate than do carcinomata. This opinion is shared by Kaufman[9] and disputed by Thompson[10] and by Rankin and Larson.[2]

Chief amongst the early symptoms of rectal sa comata are obstipation and straining at stoc Bleeding and pain occur only at an advanced sta when ulceration is present. Due to the tendency encapsulation, extension and metastasis to the lym nodes are infrequent and generalized metastas does not occur until the neoplasm has involved t adjacent blood vessels. Our case, as previous

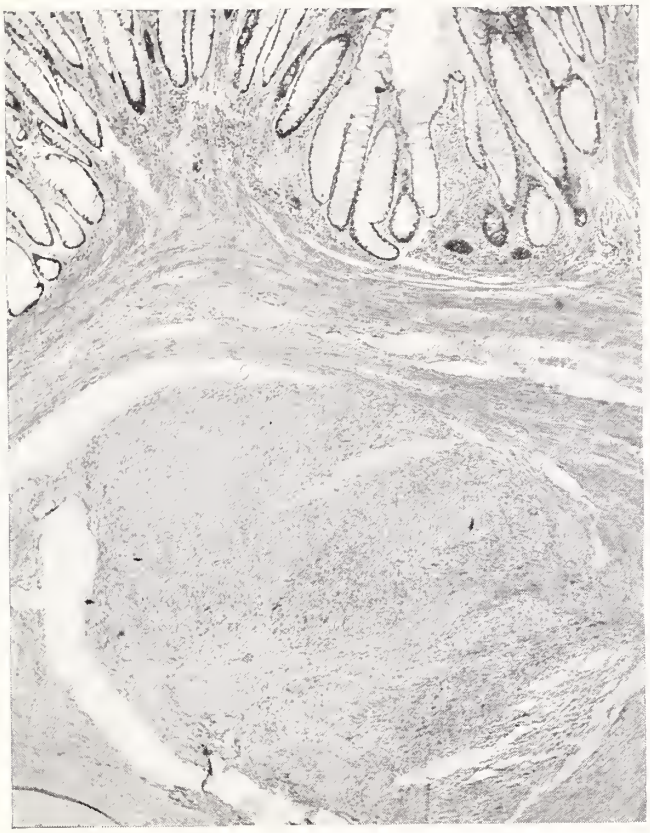


FIGURE 3
Leiomyosarcoma of rectum. H & E x 45. Sarcoma extending into submucosa

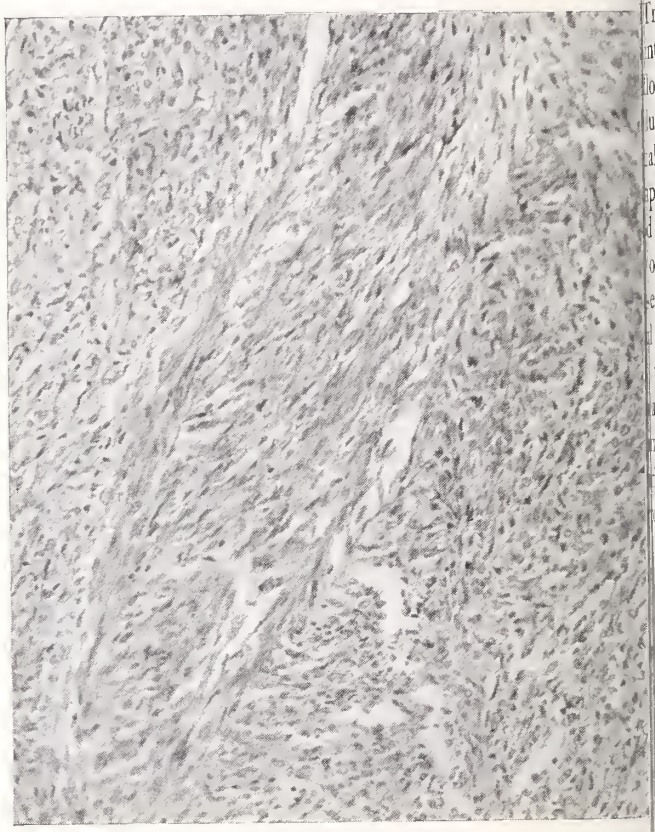


FIGURE 4
Leiomyosarcoma of rectum. H & E x 220. Interlacing bundles of fusiform cells composing tumor

Thompson,[10] in his discussion of rectal sarcomata, states that they start out as small, firm, nodular, freely movable, submucosal masses which are not attached to the mucous membrane. As they enlarge they encroach on the lumen of the bowel and stretch the mucosa so that it eventually undergoes ulceration. They are firm in consistency, comparable to leiomyomata of the uterus, and may simulate a malignancy of the prostate on rectal examination. The lesion is said to predominate in men over women in a ratio of 5 to 1. The age range is in the fifth and sixth decades. Definite diagnosis depends on microscopic examination. This is also the opinion of Rankin and Graham[4] and Kaufman.[9]

mentioned, showed no evidence of lymphati spread.

Differential Diagnosis: Clinically, leiomyosarcon of the rectum is to be distinguished from carc noma. Leiomyosarcoma starts beneath the rect mucosa, whereas carcinoma starts in the mucos Leiomyosarcoma is more nodular and of greate volume than carcinoma. Leiomyosarcoma produce its chief early symptoms from its tendency t encroach on the lumen of the bowel and obstruc the fecal stream. Carcinoma has pain and bleedin as its usual earliest symptoms because of its pro pensity for ulceration, whereas leiomyosarcoma a tains relatively large dimensions before it ulcerate and becomes infected. Because of this characteristic

n, hemorrhage, weight loss, and cachexia occur tively early in carcinoma and late in leiomyosarna. The duration of the disease is somewhat ger than in carcinoma. Rankin and Larson[2] re- t cases of 8, 6, and 5 years' duration, following ple excision of the tumor. On the other hand, on and Scheffler's[3] case had a palpable recurce within a year following operation.

Treatment: Rankin and Larson[2] and Thompson[10] nt out that the rapid and uniform recurrence lowing incomplete removal of the growth with ure to respond to radiation means that a wide al excision is the treatment of choice. Local ppearance was an important feature of Bacon l Scheffler's[3] case although here the history was only 6 months' duration and an abdominoperineal ection had been done. Our case unfortunately not survive the immediate postoperative period that we are unable to offer any data on this ase of the disease. However, the absence of any mphatic involvement and the negative metastatic ies would appear to have offered a favorable gnosis.

MMARY

A case of leiomyosarcoma of the rectum occurg in a 49-year-old man is reported. The rarity this tumor is stressed.

(The authors gratefully acknowledge the invaluable assistance of Dr. Robert Tennant in the preparation of this paper. The photomicrographs were made by Mr. Peter De Parolis, staff photographer at the Hall-Wilson Laboratory of the Hartford Hospital.)

REFERENCES

1. Stout, A. P.: Human Cancer, Philadelphia, Lea & Febiger, 1932.

2. Rankin, F. W., and Larson, L. M.: Minn. Med. 15:833, 1932.

3. Bacon, H. E.: and Scheffler, W. A. H.: Tr. Am. Proc. Soc. 43:255, 1942.

4. Rankin, F. W., and Graham, A. S.: Cancer of the Colon and Rectum, Springfield, Ill., and Baltimore, Md., Charles C. Thomas, 1939.

5. Ewing, J.: Neoplastic Diseases. A Treatise on Tumors, Philadelphia and London, W. B. Saunders Company, 1940, 4th edition.

6. Bockus, H. L.: Gastro-Enterology, Philadelphia and London, W. B. Saunders Company, 1944, volume 2.

7. Gall, E. A., and Mallory, T. B.: Am. J. Path. 18:381, 1942.

8. Karsner, H. T.: Human Pathology, Philadelphia and London, J. B. Lippincott & Co., 1926.

9. Kaufman, E.: Pathology for Students and Practitioners, Philadelphia, P. Blakiston Son & Co., 1929 (translated by Stanley P. Reimann).

10. Thompson, J. W., Jr.: Sarcoma of the Rectum, Proc. Staff Meet. Mayo Clinic 2:240, 1927.

WORLD HEALTH ASSEMBLY — GENEVA 1948

Notes by an Amateur in Public Health

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As I sat in the doctors' lounge in the Hartford Hospital one morning late in May, nothing could ve been further from my mind than world public alth. I was feeling at peace with the world as I cked up the telephone to answer a page, and und myself talking with the State Department in Washington. Would I be one of the three official legates from the United States to the World ealth Assembly in Geneva? At first this seemed mpossible because of commitments which I thought first it would be impossible to rearrange. But it appeared that the government of the United States was anxious to have a representative of organized medicine on the delegation and I could hardly refuse such an opportunity.

At the time this offer came it was purely tentative because Congress had not as yet given its sanction for membership in the World Health Organization. In fact it was within two weeks of the opening of the Assembly that final approval was given and the President affixed his signature. This is scant time to make preparations for a dele-

legate to the W.H.A.; Trustee, AMA

gation to participate in an international congress and as it appeared later the consequences of this delay were more far reaching than the temporary uncertainty which attended our preparations.

The usual application for passports, inoculations, etc., had to be undertaken. It seems that when one represents this great country in an international congress, the Federal Bureau of Investigation is deeply concerned, and some of my friends informed me that I had been investigated. In fact on my return I received a copy of the letter which the Assistant Deputy Commissioner of the Federal Security Administration sent to the Secretary of State. It was a great comfort to know that I had been certified as a loyal and trustworthy citizen.

Since I had little time to spare at either end, I elected to fly over and back. This was quite painless though monotonous and fatiguing. On the way over we stopped at Stephensville in Newfoundland, at Shannon in Ireland, and Geneva. Returning we stopped in Paris, Shannon, Gander and New York.

In Geneva we were comfortably located at the Beau Rivage Hotel overlooking the lake near the center of town. It was in front of this hotel that a fanatic stabbed Empress Elizabeth, wife of Franz Joseph. She died in Room 120 just under Dr. Parran's office. The Palace of the Nations is about three miles distant on the hill in the outskirts of the city, in the midst of very attractive grounds and with a beautiful view of the lake, Mont Blanc and the surrounding country. These buildings, I understand, cost about 10 million dollars, but certainly they could not be reproduced for four times that amount today. They were more than adequate for our purposes, and before we were quite through with our Assembly, the Economic and Social Council of the United Nations began its meeting also. The buildings, however, would harldy be large enough for the United Nations organization, and I, for one, am rather glad that the health organization is located at such a distance from the seat of political maneuverings in New York.

Our headquarters for the delegation office occupied part of the Villa Moynier which had been the first office of the International Red Cross and prior to that had an honorable and historic past as the abode for various periods of time of Byron, Shelly, Mme. de Stael, Empress Josephine, Marie Louise, Queen Hortense, Queen Victoria and others.

Each morning the delegation met at nine o'clock at which time the documents were on hand, records of what had transpired the day before and of wh was on the agenda for the ensuing day. At the meetings matters of policy were decided under t guidance of position papers which had been giv us as we started our work. From time to time wh instructions were needed, we cabled or telephon to the State Department in Washington. This, ho ever, was not necessary very often, for our dele tion was large and it included not only experts malaria, tuberculosis, venereal disease, maternal a child health, and other matters that we were int ested in, but also competent officials from the Bure of the Budget and of the State Department itself.

Dr. Thomas Parran, chief of the delegation, h been a member of the Interim Commission engag in developing the World Health Organization ov the previous two years. Dr. H. Van Zile Hyde h been an alternate with him, as had also Dr. Jan Doull, both of the United States Public Health. I Martha Eliot, of course, was interested in the Ch dren's Bureau and had been actively engaged as advisory member of the United Nations Interr tional Children's Emergency Fund.

I thought it somewhat strange, looking over t competence of this delegation, that a practitior of medicine inexperienced in the arts of internatio al negotiations should have been designated as o of the 3 official delegates. I could not help but f that it was a good omen that both the governme and organized medicine felt that practising phy cians should take their place shoulder to shoul with those who are interested in organized pub health. Nevertheless, I felt often like an amate among professionals. It took me more than a f days to catch on to the system of documents, learn what was important and what could be te porarily disregarded, and most of all what I co get somebody else to do. Some of the observers, li myself, were relatively unskilled in the transacti of official business, but we were never made to f uncomfortable and I believe that every member the delegation pulled his weight in the boat.

The World Health Assembly marked the beg ning of World Health Organization activities a the termination of the interim phase which beg at the International Health Conference in N York during the summer of 1946. The Assemb took as its agenda the recommendations of t Interim Commission. These were thoroughly d cussed, altered and adopted, focusing attention some of the long-term health needs of the peop of the world.

The Program Committee recommended to the World Health Assembly that malaria, tuberculosis, maternal and child health, venereal disease, environmental sanitation, and nutrition be given first priority. These were accepted and referred to the Director-General of WHO to carry them forward immediately. The Assembly adopted measures to arrange for international standards for therapeutic, prophylactic and diagnostic agents, for an international pharmacopoeia and an international epidemiology, looking toward uniform quarantine requirements.

Plans were approved also to continue and to develop the fellowship program, training personnel for public health in those countries which do not have adequate training facilities. Emphasis was laid on public health nursing, the development of hospital services and medical care, medical rehabilitation, control of certain parasitic and various diseases. The mental health program would probably be developed in the light of recommendations of the International Congress on Mental Health which was to meet in London during August.

In spite of the difficulties of language and against the backdrop of political upheavals in Berlin and in Yugoslavia, and while the difficulties between East and West were real, at the World Health Assembly they were less than I could have thought possible. Professor Stampar of Yugoslavia was elected President of the Assembly, and he also represents his country on the Executive Board. Dr. Brock Chisholm, formerly Surgeon-General of the Canadian Army, later Chief Medical Officer of Canada, had been the Executive Secretary at the Interim Commission and was designated Director-General of the WHO.

The budget of $4,800,000 was set for 1948. This allows repayment of the expense incurred by the Interim Commission and sets up a capital fund of $1,650,000. This sum of money, large as it seems to us as individuals, is relatively small as against the needs of the world for public health. Indeed, it seemed difficult for some of the delegates to realize that the World Health Organization was not a pot of gold into which they could dip with freedom. It was clearly brought out in the end that the World Health Organization was rather an integrator, an inspirer of programs. In fact the most significant thing that happened at the Assembly was the speedy division of the entire world into six regions, the problems of each of which are slightly different. Responsibility and expenses will be decentralized. These regions are Europe, Eastern Mediterranean, Africa, South Eastern Asia and the Western Pacific with the Western Hemisphere cared for by the Pan-American Sanitary Bureau. Complete integration of this Bureau as a region of the World Health Organization has not yet been accomplished, due to some technical difficulties. However, we are further advanced in this hemisphere than any other region in the degree to which nations in the Americas share each others public health burdens, and cooperate in their solution.

The election of the Executive Board of 18 caused some little difficulty. No rules of procedure had been laid down and it was no mean accomplishment to get agreement under any circumstances which would give reasonably adequate recognition of the interests of the six regions and of the present membership. In this matter the Western Hemisphere obtained only 3 seats on the Executive Board, the United States, Mexico, and Brazil, Canada being indirectly represented by the Director-General. If Congress had hastened the acceptance of this country, it is probable that all of Latin America would have joined also, and our position as leader of 21 countries in this hemisphere would have been more effective than it was as leader of a mere handful of member nations.

It is perhaps unwise and impolitic to speak of leadership in any such international gathering, though as practical individuals one listens more attentively to representatives of Russia, United Kingdom or the United States, than, let us say, to Monaco. One could count 5 United Kingdom votes on the Executive Board, for the ties of the old empire are very strong, and, of course, one understood without being told that Russia headed a block of 8 members of the Assembly of whom 4 are represented on the Executive Board, one-half of the total European representation. Dr. Shousha Pasha of Egypt was elected chairman of the Executive Board. He is an able public health administrator, capable of impartial leadership. He was supported successfully by our delegation.

The United States delegation put in a resolution, however, backed by several other countries that this method of selection of the Executive Board should not be a precedent and the Executive Board itself must bring to the next Health Assembly a definite rule of procedure.

It must be remembered that our delegation was

seated only temporarily for the first week. This was due to a technical difficulty since Congress had attached two conditions to our membership. First, a limit to the amount of money that the United States would furnish; and second, a definite statement concerning withdrawal of membership to the effect that we proposed to give one year notice and that all just debts would be paid. The Assembly waived these conditions and we were seated.

Again in the final session it was necessary for our delegation to make a strong statement concerning the contributions to be made by this country and others. The scale of contributions adopted was that of the United Nations which made the contribution of the United States nearly 40 per cent of the total. Some of the delegates complained bitterly that $4,800,000 was not enough and indeed, the Interim Commission called for a budget of between 7½ and 8 million dollars. Our delegation pointed out that it is unwise for any organization to depend so largely for financial support on any one of its members, lest financial matters be given undue consideration. In fact if the contribution of the United States were reduced to 25 per cent, the budget recommended by the Interim Commission could be adopted. The delegates from other nations, however, seemed to have been committed to the lower figure.

The agenda for the Assembly had been available a few weeks before we convened on June 24, and the delegates had had some chance to familiarize themselves with it. The Assembly was admirably organized. Each country has one vote. The official languages are French and English. Russian, Spanish and Chinese also are allowed and are translated into both of the official languages. Chinese was not used at all since all of the orientals, in fact Indians and many of the Europeans, spoke English.

The work of the Assembly was handled in two ways. Certain matters of broad policy were referred to the General Committee for consideration and report. This consisted of 15 members of the Interim Commission, later replaced by the Executive Board of the World Health Organization of 18 members. The major part of the work of the Assembly, however, was transacted by 5 committees, program, headquarters and regions, relations, administration and finance and legal. Each one of these committees had representatives from each of the members. They were, therefore, committees of the whole and reports which they adopted and placed before the Assembly seldom required argument.

Dr. Eliot assisted by Dr. Halverson, director o health in California and many others cared for th Committee on Programs. Dr. James Doull repre sented us on the Headquarters and Regional Com mittee. My assignment was representative on th Relations Committee assisted by Dr. Corrigan, former surgeon of Cleveland, and a diplomat wit extensive experience in South America in the Stat Department. In fact he had been Ambassador t Venezuela. Mr. Calderwood of the State Depart ment and Nelson Cruikshank of the American Fed eration of Labor also assisted me from time to time The Relations Committee had particularly to d with relations with United Nations and its specialize agencies, and also with nongovernmental agencie which might apply for a relationship status with th World Health Organization or might be invited t participate in its work. Dr. Hyde, who was ou representative on the Administration and Financ Committee, and Mr. Sandifer of the State Depart ment represented us on the Legal Committee. Eac of us was responsible either personally or throug one of our assistants to have a synopsis of wha transpired in the daily meetings of the committe in the hands of Dr. Parran during the evening, s that appropriate action might be prepared for th following meeting of the committee, and discussio might take place at the meeting of our delegatio next morning.

A few days after we had begun our meeting Congressman Ivor Fenton, graduate of Jefferso Medical School in 1912 and a member of the Appro priations Committee of the House of Representa tives, came as a Congressional observer. I was very glad that they had seen fit to send a physician. I anyone thinks that Dr. Fenton was on a junket, can disabuse him of that idea. He attended ou delegation meetings as one of the delegation an followed closely the meetings of the committee a the Assembly. I am sure that the Appropriation Committee of the House of Representatives wil have a good report from him of what the Worl Health Organization is about.

The Assembly took one action which is historic It adopted regulations for reporting of diseases accidents and deaths. This regulation is a conven tion to be adopted by member nations, and it is t go into effect if after a stated period of time th individual nations do not refuse to cooperate. This then, is actually the first international law to b passed by any international assembly. It will b

nteresting to see if it obtains widespread adoption nd support. This underlines the thought that many ave had that health considerations will lead the ay toward international good feeling.

The World Health Assembly adopted also the ecommendations of the experts on nomenclature of isease which had met in Paris during the preceding pril, and certain selected groups of diseases and ccidents were set up and codified for statistical tudy on an international basis.

All work and no play makes Jack a dull boy, nd Switzerland is a delightful place to be in when he weekend rolls around. Apparently the Swiss Chamber of Commerce has an inside track with the eatherman for most of our weekends were delightul. We spent one Sunday on the lake visiting the Chateau of Chillon, another Sunday we took a bus ide to Chamonix and the Mer de Glace. On another went on an auto trip to Neuchatel, Fribourg, Gruyère and Montreux, and on the last Sunday Colonel Whayne of the Surgeon General's office nd I went up the Jungfrau.

On one weekend a party of us were invited to isit Basle and were shown the Ciba Company's lant. Some visited the Geigey plant where D. D. T. manufactured. I visited the wonderful Buergerpital, the municipal hospital of which the inhabiants of Basle are justly proud.

Living in Geneva is also comfortable. It is not heap but food is prepared better, and at about half he price found in restaurants in this country. Open vines are excellent and when the weather is warm, s it was during the last week, swimming in the lake stone's throw from the hotel is invigorating.

The Swiss people look happy. Their children are vell fed and contented. None of us saw a mother lap a child or speak unkindly to it. We observed ank traps on some of the strategic roads in the narrow valleys to the north and everywhere on Sunday one could see in the railroad station boys and men up to 60 years of age with service rifles slung across their shoulders on the way to or from target practice.

I spent a whole morning in the cantonal hospital with the professor of gynecology and obstetrics, Dr. Watteville. I saw his entire plant, some interesting and progressive work in hormone research and work with the Papanicolaou smear technique. I observed thorough and advanced methods. He is relatively young, vigorous and alert. It was vacation time but the assistants appeared to be eager and well informed. He showed me plans for a new modern clinic building. I entered in my mind the silent hope that he would have screens at the windows to diminish the plague of flies which even D. D. T. could not cope with. Perhaps by the time we visit Geneva again, they will also have discarded the roller towels in the marble Palace of the Nations.

I am glad I went. I am convinced that public health the world around for a long time is going to be short of trained personnel, and that practising physicians not only can but must be made use of as supplementary and assistant health agents. Before I left I was asked to make a record at the radio studio supposedly for official records at the United Nations and for rebroadcast on occasion in this country, and I took occasion to say that I look forward to the day when every health official will be medically trained, and every physician will consider himself a public health officer. I noted that there had been less difficulty between the delegates of the various nations than I had thought possible, and added that if we cannot as health-conscious people get together across international boundaries, there is little hope that we can have lasting peace in the world.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Our Postgraduate Opportunities

The announcement of the completed Clinical Congress program and of the postgraduate courses to be given at the Yale School of Medicine shows something of the objectives toward which the committees on postgraduate education of the Society and the Medical School are directing their attention. The Clinical Congress, now well established as a significant cooperative enterprise, remains largely in its usual form and is one of the best gatherings of its kind to be held anywhere. The high quality of the 1948 program is the result of careful deliberation by the Program Committee aided by information gained from many sources. The projected postgraduate courses likewise have much of their origin from information secured through the questionnaire in which many physicians expressed their preferences. In planning this course program, the Committee has a single objective which is to bring to the doctors of our State opportunities which will be of educational benefit to themselves. If such study is given credit by any specialty board, it will be entirely incidental to the planning of the program.

It is certain that as the program progresses courses will be expanded and augmented, for the primary experience will give valuable information to the Program Committee. At this time they are to be congratulated on so auspicious a beginning. The support of the members of the Connecticut State Medical Society should come forward enthusiastically.

Intern Problems

As a part of modern medical education, intern training has come to be regarded as important as any part of the undergraduate course of study. A witness to this fact is seen in the present intern enrollment of the "teaching" hospitals over the "non teaching" hospitals. Thus, on April 1, 1948 58 per cent of the former reported no vacancies against 26 per cent of those of the latter group which are also approved for intern training. It is apparent that the non teaching hospital faces a problem which is concerned not only with the filling of ranks of the intern staff but also with the teaching responsibilities of the attending staff. Unless internships are attractive and worth while from the viewpoint of good instruction, they will not be sought by the senior medical student. In considering the present distribution of interns, the question has been raised as to whether some hospitals need as many as they seek and it has also been raised as to whether some approved hospitals should be approved at all. It is apparent why non approved hospitals and many of the smaller approved hospitals suffer and will continue to experience a lack of interns. This problem is being met by some institutions in the employment of men as house officers who have completed intern training and in the employment of men on a part time basis who are beginning to establish a local practice. This has produced very satisfactory results and is a development which warrants further study. With hospital expansion going on as never before, the intern needs

of the larger hospitals will also greatly increase. The small hospital which is not prepared to offer in good measure the educational advantages of the larger institution may consider two courses of action, one, to become associated in an intern training program with a larger institution, a plan which is being successfully developed in certain areas, and another to consider the employment of men who have finished intern training.

Connecticut Diabetes Association

The Connecticut Diabetes Association, organized during the annual meeting of the State Medical Society last April, is planning state-wide operation this fall. It is the ninth in a series of 35 regional organizations being sponsored by the American Diabetes Association to standardize diabetic care. Wide interest has already greeted the new association, and this is perhaps the best indication that it is a sound approach to a health problem which has long disturbed physicians who number diabetics among their patients, as well as specialists in this field.

Diabetes is an important health problem. It is estimated that there are approximately one million diabetics in this country today, and more than fifty thousand new cases developing annually. Besides the million persons in our country who know they have diabetes, surveys by the United States Public Health Service and other agencies indicate a million more undiscovered diabetics. For every four cases that are known at least three more new cases can be found. Thus, the need for an organized attack on this major health problem is obvious.

Simple regulation of the diet can overcome the effects of mild diabetes; even the most severe cases of diabetes can be treated successfully with insulin. Yet many cases continue to be neglected or half-treated, causing needless disability and death. Today's medical knowledge concerning the use of insulin and proper diets in controlling this disease promise a considerable increase in the number of diabetics restored to normal living.

Objectives of the new associations will be to find the million hidden cases of diabetes, promote earlier diagnosis, and see that known diabetics are offered effective medical management. The rapid advances in the control of diabetes, the introduction of new insulins and new techniques in treating the disease and its complications have created a greater need for specialization. But the large majority of diabetic patients come under the care of the general physician, and his needs must be met.

The American Diabetes Association and its affiliated organizations have embarked upon a significant educational program. Its aim is to make authentic information concerning the care of diabetics available to the physician, the patient, and relatives and friends responsible for the patient's care. More adequate facilities for the treatment of diabetes is another objective of the program.

Professional membership in the Connecticut Diabetes Association is open to all physicians, regardless of specialty, and policy control will be vested in this group. Associate members will include those in allied professions having an interest in diabetes, as well as diabetics themselves and their relatives and friends. The association will be self-sustaining through nominal membership dues.

The officers of the Association are president, Dr. Barnett Greenhouse, New Haven; first vice-president, Dr. Burdette J. Buck, Hartford; second vice-president, Dr. Anthony Cipriano, New Haven; secretary, Dr. John Dobkins, Stamford.

Members of the association's council are Dr. C. N. Hugh Long, dean of the Yale University School of Medicine; Dr. Eugene E. Lamoureux, Connecticut State Department of Health; Dr. Samuel J. Goldberg, Dr. Herbert Levine, and Dr. Bernard L. Kartin, New Haven; Dr. Michael E. Brodsky, Bridgeport; and Dr. Max Ruby, Waterbury.

In this new venture Connecticut is again leading in the march toward better health services. It merits the support of every physician.

Therapeutic Propaganda and the Public

Too much of a good thing is good for nothing.
Old Saying.

When an elderly person glances nowadays through the pages of a daily paper he is struck by the absence, at least in the reputable sheets, of the blatant and often misleading patent medicine advertisements which were so common forty or fifty years ago. In the popular weeklies too, much more space is given to minor matters such as halitosis, B.O., or athlete's foot, or to the necessity of having glamorous hair, than even to such common complaints as constipation, though an occasional exploitation of some mild laxative may at times

creep in. No doubt this change is only partly due to the influence of the pure food and drug laws and to the fact that the public, who have uncritically swallowed many of the published statements, are excessively bowel-conscious as compared to their ancestors and, in recent years, are sold on vitamin deficiencies and some other common phenomena. The main cause of the change, we suspect, is the prostitution of a new medium, radio, to the uses of the medicine vendors, for to many people the human voice, particularly the seductive and saccharine statements of radio announcers, make a greater impression than the printed page and, like the old newspaper advertisements, permit the omission of any reference to the fact that some of the products which they ballyhoo, may, in excessive doses, cause damage to the patient.

Physicians know that when it comes to therapeutics the great public, particularly its less intelligent members, have some curious ideas. There are racial groups who think that physicians have some sort of almost specific remedy for every disease, but much more common is the notion that if the recommended dose of a remedy is good a larger one must be better. Nor is it uncommon for patients to use up old medicines when they develop symptoms similar to those for which the remedy was originally prescribed. People often suggest to friends the use of remedies which have been successful in themselves simply because the friends have similar symptoms. In many cases the remedies suggested are patent rather than proprietary and therefore of unknown composition, but in recent years radio commercials covering certain types of proprietary articles have been common. Every doctor now knows that constipation rather than life begins at 35 and that the average American diet is lacking in vitamins.

It is to the possible damaging effect of these accessory food factors that we wish to call particular attention, for they may be and are freely sold over the counter without a physician's prescription. It is true that some manufacturers suggest on the label that a physician should be consulted as to dosage, but others simply state the contents of each dose and few if any, so far as the writer is aware, state that overdosage may cause harm. Dickey and Bradley have recently reported a typical case of Hypervitaminosis A in a child with pains in the arms and legs, irritability, general pruritus and periosteal elevation in some of the bones. The mother had been giving the child excessive doses of Vitamin A, and when this was eliminated prompt recovery occurred. Vitamin B in excessive dosage may also cause symptoms, mainly in the form of gastrointestinal distress, and too much Vitamin D may cause irreversible damage to the cardiovascular and renal systems by leading to excessive local deposition of calcium. While such occurrences are most likely to occur after injudicious home medication, it is important that physicians bear in mind the danger of hypervitaminosis and that they warn patients to whom they suggest the use of vitamins.

G. B.

Stanford Medical Bulletin, 1948, 6, 345.

New Annual Review of Medical Progress

Elsewhere in the JOURNAL will be found an announcement of *Medicine of the Year*, an annual review of medical progress to be issued as a supplement to the CONNECTICUT STATE MEDICAL JOURNAL appearing early in 1949. The Society has provided this feature for its members in the belief that it constitutes a valuable educational opportunity at small expense and one which will be a distinct benefit to all who subscribe. The contributors are all men of outstanding reputation in their field, distinguished as teachers and medical writers. Their names guarantee a comprehensive and critical account of the significant and important events in medicine during the preceding year, well written and of practical interest to every physician. The cost is nominal.

The arrangement by which this Annual Review is made available to members of the Connecticut State Medical Society requires that a certain proportion of the members subscribe to this service if it is to be provided. The value of the service is sufficient reason for subscribing. However, because of the short time remaining in which to ascertain the number of subscribers, it is urged that subscriptions be entered promptly in order that a sufficient number are obtained to insure that the annual will be available to all who wish it. *Subscribe now!*

PROGRESS IN CLINICAL MEDICINE

TREATMENT OF ARTHRITIS

GEORGE A. WULP, M.D., *Hartford*

PROBABLY no other disease has "enjoyed" such a variety of "cures" as has Arthritis. The patient need but mention a joint pain and he is deluged with a variety of medications, nostrums, diets of omission or addition, voodooistic stunts and pain removing charms. The fault of this probably lies within the medical profession, most members of which in the past have been too prone to dismiss arthritis patients with a casual shrug, or if any treatment was suggested, it was done with such obvious hopelessness that it left the patient without any intention of following it.

The patient with arthritis was (and often still is) tossed from physician to physician, from quack to medical profession and back to quack again, with the various treatments of friends and relatives being taken on the rebound, until he finally finds himself a helpless cripple in mind as well as in body.

Although the specific cause of rheumatoid arthritis is still unknown, many predisposing factors such as physical, mental or emotional strain; infection; undue exposure to a strenuous or unusual environment, etc., are recognized. Not only is there no known etiology, but there is also no known specific cure. But the medical profession is beginning to lose some of the old hopelessness in its approach to this disease. There is an increased interest in research, clinical and scientific, not only in the field of rheumatoid arthritis, but of the arthritides in general. The American Rheumatism Association in conjunction with other groups, is in the process of raising funds to be used for furthering the study of arthritis and in establishing fellowships toward this end.

The treatment of rheumatoid arthritis at present can be divided into three groups, namely, (1) those which rest on sound principles and are of proven value, (2) those which have had optimistic reports published about them but not having been proven of real value and (3) those of questionable value only or useless.

Those modalities of proven value will, in the majority of instances, produce beneficial results, but only if they are fully explained by the physician and if they are fully understood and conscientiously followed by the patient. They consist of (a) rest; this must be physical, mental and emotional. Rest in bed will be of no avail if the patient's muscles are in continuous spasm; or if the patient is restless in mind, (b) graded exercises; these are for the the prevention of stiffness or deformities. A good orthopedic consultant and an intelligent physical therapist are helpful in outlining these procedures, (c) an adequate diet fitted to the needs of the individual patient, (d) medications; iron and vitamins for the correction of anemia and under nutrition, aspirin for control of pain, (e) removal of any foci of infection because this is good hygiene and not because of any specific relationship of the infection to arthritis, (f) physical therapy, occupational therapy and psychotherapy; the patient must be kept happy through what may be a tedious illness, or treatment might as well be stopped.

The use of *x*-ray is helpful primarily, if not only, in the treatment of Marie Strumpel arthritis, but here it gives relief of pain and freedom from stiffness in as high as 90 per cent of the patients on whom it has been used.

Of the measures for which there have been optimistic reports but which are not of proven value, gold is the most outstanding. The basis for its use is still unknown and there is still considerable discussion as to its merit. The tendency at present is to use smaller doses than formerly, making a course extend over a longer period of time and then giving maintenance or booster doses at intervals of four to six weeks, over a still longer period. However,

even with this routine, there is still rather a high percentage of complications and no patient should be given gold without being carefully examined for signs, symptoms and laboratory indications of gold toxicity, before each injection.

Among the measures which are of questionable value the administration of large doses of vitamin D is the only one meriting discussion, and then from an adverse point of view. Evidence is accumulating which points to the dangers of prolonged vitamin D therapy, with not a few recorded deaths. Self medication is indulged in quite freely and it is still prescribed but there is not any real evidence supporting its use.

The arthritides (rheumatism in general) rank first in prevalence among the chronic diseases and second in producing disability. Only recently has there been any optimism regarding its treatment; there still is a lack of enthusiasm, which must be overcome before our optimism can be transmitted to the patient.

Actuarial Society Analyses Surgical Benefit Claims

Boys incur 15 per cent more surgical operations than girls, with 60 per cent of all children's operations being tonsillectomies and 20 per cent appendectomies or fractures, according to an analysis of 100,000 surgical benefit claims of all ages made by a committee of the Actuarial Society of America and presented at the annual meeting of the Society in New York.

This was one of a long list of findings from the study which covered group surgical insurance claims reported by companies doing 70 per cent of this type of insurance and covering a period of eight months of last year.

Group surgical insurance, first written in 1938, has become an important segment of the insurance business, covering 10,000,000 persons, the report stated. This insurance, added to protection on an additional 10,000,000 covered by Blue Cross, individual contracts or other plans, gives a total of over 20,000,000 persons now protected by surgical benefit insurance.

Eight types of operations were found to account for the greater part of all surgical benefit claims: tonsillectomy, appendectomy, benign tumor or cyst, hemorrhoidectomy, fracture, hysterectomy, herniotomy and dilation or curettage. These accounted for 60 per cent of all claims, 57 per cent of the male cases and 67 per cent of the female cases.

Multiple operations take place in a large number of cases, taking advantage of the urgency of the major cause. In 17 per cent of all cases, more than one operation was performed under the one procedure; in the case of claims for wives, 31 per cent were multiple, for female employees, 24 per cent, for male employees 15 per cent and for children 5 per cent. In gynecologic surgery, a maximum of 51 per cent was shown. On the average, multiple operation claims were for amounts almost double those for single operations.

More complicated surgery was incurred at ages over 50 in the case of men. For women, the operations were generally more serious than for men at all ages, but the severity changed little with age, except for a slight peak in late child-bearing or post child-bearing years.

Not all surgery is performed in hospitals, the report shows, though most of it is. Men show a higher out-of-hospital surgery incidence than women. In the case of men, 23 per cent of the operations were performed out of hospitals, for children, 16 per cent and for women 11 per cent. The average amount paid for out-of-hospital claims was less than one-third that for hospital surgery.

Taking appendectomy as an example, it was found that 30 per cent of the doctors charged not over $100; 50 per cent not over $125; 80 per cent not over $150; and 90 per cent not over $165.

The analysis was said by the committee to indicate that charges were usually higher for male employees than for women, reflecting the general practice of suiting fees to the ability to pay.

Analysis of surgical fees in the cases covered showed that charges were highest on the west coast, with California showing the highest cost of any state. In California the charges were 39 per cent greater than the U. S. average in non obstetrical cases and 61 per cent over average in obstetrical; in the middle Atlantic states, next highest, the charges were 3 per cent and 5 per cent higher than average, respectively. The south Atlantic states showed the lowest cost, 12 per cent and 9 per cent, respectively, below average.

The average surgical claim for male employees was $48, for female employees $63, for wives $71, for male children $34 and for female children $37.

THE PRESIDENT'S PAGE

The experience in economics of the average physician is usually a rather simple one consisting for the most part of attempting to collect fees for his services on the one hand and of endeavoring to pay that which he owes on the other. If by any chance he has a surplus and ventures beyond this into more complicated matters such as investment, he does so either timidly or with temerity and not infrequently the result is an unfortunate one. The "sucker" lists are composed in considerable part of physicians, clergymen and professors.

It is not surprising then that the medical profession is prone to regard any seemingly intricate economic problem with suspicion if not prejudice. Particularly is this true where the terminology employed in its exposition is susceptible of misunderstanding, because of the manner in which it is used or as a result of invidious connotations that have been acquired in common usage.

Reactions of this nature have been apparent in the many discussions that have taken place in the past year concerning a "prepayment plan" that provides partial or complete "indemnity" for certain costs involved in medical care.

The word "plan" in recent years has come to have—whether with justification or not is aside from the point—an implication of underhandedness or intrigue. It seems to be acquiring the same meaning as "scheme," which was once a respectable term that carried with it no opprobrium. But whenever two or more individuals intend to act in coordination it is necessary to project their actions into the future, in other words to plan, and while this may be for improper purposes and by dishonest means, this is not necessarily so. At least it should not be assumed that this is the case because of the possible invidious connotation of the word.

While "indemnity" has so far as I am aware no distinction of this nature, it seems to be confusing when used in conjunction with the provision of medical care. It is defined as compensation for loss sustained, in this instance the cost to the patient of certain professional services. He is the recipient or indemnitee and the corporation organized for the purpose of obtaining and distributing the monies involved is the payee or indemnitor.

The physician cooperating with this plan agrees that when the income of the indemnitee lies below a predetermined level, he will accept as "full indemnity" to the patient for his services a fee as established in a fee schedule. The patient then waives his right to the receipt of the indemnity and thereby enables the corporation to reimburse the physician directly. This is referred to frequently as a "service contract," but is better called "full" or "complete" indemnity.

When the income of the patient lies above this predetermined level, he is indemnified to the extent indicated in the fee schedule but is himself liable for the remainder of the fee that the physician may see fit to charge. This is "partial indemnity" and differs in no respect from that now provided by many insurance corporations.

Samuel C. Harvey

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1949 ANNUAL MEETING

The Hartford County Medical Association has invited the State Society to hold its next Annual Meeting in Hartford County in the spring of 1949 and the Board of Directors of the Association has appointed the following Local Committee on Arrangements: William J. Watson, New Britain, chairman; Harold M. Clarke, New Britain; Thomas M. Feeney, Hartford; Philip J. Moorad, New Britain; John S. Papa, Bristol; and Charles T. Schechtman, New Britain. It has been proposed that the meeting be held at the New Britain State Teachers College and the suitability of the college buildings for the increasingly large and complex annual sessions is now under study.

European Assignment for Secretary

Dr. Barker has been appointed to serve as an alternate delegate from the American Medical Association to the 1948 Assembly of the World Medical Association which will convene in Geneva, Switzerland, on September 7. Certain of the delegates, including the Secretary, have been requested by the Army to go into the Occupied Zones after the Assembly adjourns and observe medical care conditions in these areas and Dr. Barker will be absent from the office until the end of September.

New Committee on Postgraduate Education Meets

The Committee on Postgraduate Education, elected by the House of Delegates at its annual meeting in April, after revision of the By-Laws, to replace the Committee on the Clinical Congress, held its first meeting jointly with the Committee on Postgraduate Studies of the Yale School of Medicine on Monday, July 26 in New Haven. There were present from the Society's committee, Courtney C. Bishop, New Haven, chairman; Bliss B. Clark, New Britain; John C. Leonard, Hartford; and from the Medical School, William R. Willard, New Haven, chairman; William T. Salter, New Haven; Herbert Thoms, New Haven and Paul I. Yakovlev, Middletown. Ashley W. Oughterson, New Haven; Creighton Barker and Grace Mooney also attended the meeting, which was devoted largely to description and discussion of the postgraduate program to be offered by the School of Medicine for Connecticut physicians during 1948-1949. An excellent variety of courses in various fields of medical practice and in preclinical sciences has been planned and detailed announcements of the schedule will be sent to all physicians in the state in the near future.

Progress on Prepaid Medical Service Plan

A sub-committee of the Committee on Prepaid Medical Service, comprised of James R. Cullen, Hartford; Thomas J. Danaher, Torrington and Joseph H. Howard, Bridgeport has met twice with representatives of the Incorporators of Connecticut Medical Service including Robert S. Judd, New Haven, chairman; D. Spencer Berger, New Haven and Francis H. Griffiths, Torrington. Substantial progress has been made in arriving at agreement on the general principles involved in the establishment of a voluntary, nonprofit, prepaid medical care plan. Inquiries made by the State Society office provided data concerning average earnings of employed persons in Connecticut and enabled the Committee to set tentative income levels for service groups and to start work on the schedule of indemnities. Mr. Robert Parnall, general manager of Connecticut Hospital Service, Dr. Barker and Miss Mooney are engaged in the development of By-Laws for the Corporation.

Building Fund

The Board of Trustees of the Building Fund has announced that the architect's plans for the Society's building have recently been revised in order to bring the costs into line with the funds available. It was also announced by the Board that over $79,500 had been pledged and nearly $74,000 has been paid to date. Memorial and special gifts amount to $9,490 of the total. Pledges have been received from 1,142 members of the Society. Non-contributors are reminded that, if pledge cards have been mislaid, checks may be sent in without cards to the Board of Trustees of the Building Fund, 258 Church Church Street, New Haven.

Food, Drugs, Cosmetics and Devices Committee

The Connecticut Committee on Foods, Drugs, Cosmetics and Devices on which Dr. Gray Carter, Greenwich, serves as the representative of the Society held its first meeting on June 22 in New Haven. The general purposes of the committee are stated as follows:

"In a very general sort of way, this Connecticut Committee would serve on a local scale the same function as is served on a national scale by the American Medical Association Council, the Council of the American Pharmaceutical Association and other national groups organized along the same lines.

"The purpose of this Committee would be to supply state agencies and other interested groups with a disinterested opinion as to the therapeutic status of various remedies or other preparations which might influence health.

"The Committee would render confidential statements on the merits of preparations to well authenticated agencies or groups such as the State Board of Health, or to their officers. The majority of such statements would be based on experience, either personal or solicited. Occasionally chemical or pharmacological testing would be required. Therefore, the Committee could add members on a temporary basis to cover specific situations as they arise.

"The official state agencies have already pointed out that they would welcome the formation of such a Committee to supplement their efforts. Already having received this endorsement, it is our proposal to organize this group so that it will become the semi-official agent of all the professional societies involved."

The participating societies and institutions and their representatives on the Committee are as follows:

Connecticut Agricultural Experiment Station, Dr. Harry J. Fisher.

Connecticut Pharmaceutical Association, Nicholas W. Fenney.

Connecticut State Dental Society, Dr. J. J. Englander.

Connecticut State Medical Society, Dr. Gray Carter.

Connecticut State Veterinary Society, Dr. E. H. Patchen.

University of Connecticut, Dr. Stanley E. Wedberg.

University of Connecticut College of Pharmacy, Dean Harold G. Hewitt.

Yale University School of Medicine, Dr. William T. Salter.

The official enforcement agencies concerned are represented by Mr. Herbert Plank for the State Food and Drug Commission and by Dr. Eugene E. Lamoureux for the State Department of Health. Dr. Fisher is secretary of the Committee.

Tumor Committee Plans

Allan J. Ryan, chairman of the Committee on Tumor Study; Samuel C. Harvey, president of the Society; Thomas P. Murdock, chairman of the Council and Creighton Barker, executive secretary had a special meeting recently to discuss the projects of the Committee for the coming year, with particular reference to consultative services for tumor clinics and the cancer educational program for physicians.

Connecticut Cancer Bulletin

The second series of the Connecticut Cancer Bulletin has been distributed by the Connecticut Cancer Society to more than nine hundred physicians who requested it. This is a continuation of the series sent to all of the physicians in Connecticut last year. Members of the Society who did not request the second series can obtain it by writing to the Connecticut Cancer Society, 1044 Chapel Street, New Haven.

Candidates Certified for Licensure

The Connecticut Medical Examining Board at its executive meeting in July announced that since the March meeting of the Board 81 candidates had been certified for licensure to practice medicine in Connecticut on endorsement of credentials. Of these 46 presented certification by the National Board of Medical Examiners and 35 submitted licenses issued by the following states: New York—10, Ohio—5, Pennsylvania—3, Illinois—2, Indiana—2, Michigan—2, and California, Colorado, Delaware, Georgia, Maryland, Massachusetts, Missouri, New Jersey, North Carolina, Vermont, Virginia—1 each.

Meetings Held During July

Thursday, July 1, 4:00 P. M.
Committee on Statewide Blood Bank

Tuesday, July 20, 4:00 P. M.
Sub-committee of Committee on Prepaid Medical Service, Quinnipiack Club

Monday, July 26, 6:00 P. M.
Committee on Postgraduate Education, New Haven Lawn Club

Tuesday, July 27, 4:00 P. M.
Executive meeting, Connecticut Medical Examining Board

6:00 P. M.
Committee on Veterans' Medical Service, Graduates Club

Thursday, July 29, 4:00 P. M.
Committee on Prepaid Medical Service

Friday, July 30, 4:30 P. M.
Committee on the Clinical Congress, New Haven Hospital

Dr. Barker to Attend World Medical Association

Dr. Creighton Barker, executive secretary of the Society will attend the first meeting of the World Medical Association to be held in Geneva, Switzerland, September 8-11 inclusive. Dr. Barker will be present as an alternate delegate with Dr. John W. Cline of San Francisco. The regular delegates from the United States are: Dr. Roscoe Sensenich of South Bend, Indiana, president of the America Medical Association, and Dr. Elmer L. Henderso of Louisville, Kentucky, chairman of the Board c Trustees of the AMA. Dr. Ernest E. Irons, pres dent-elect of the AMA will attend as guest. D Louis H. Bauer of Hempstead, Long Island, a mem ber of the Board of Trustees of the AMA is execu tive secretary of the World Medical Associatio with headquarters in New York City. Followin the Geneva meeting, Drs. Sensenich, Henderson Cline, and Barker are invited to make observation on medical care in the occupied zones of Germany and Austria.

Dr. A. L. Baker to Elmcrest Manor

Dr. V. Gerard Ryan, physician-in-charge of Elmcrest Manor, a sanitarium hospital located in Portland, Connecticut, has announced Dr. Asher L Baker's association with him in the practice o psychiatry and the treatment of patients with nervous and emotional disorders.

Dr. Baker graduated from the Medical College of Virginia in 1928 and for many years was associated with the Craig House in Beacon, New York. He has done postgraduate work at the Neurological and Psychiatric Institutes of Columbia University and for several years was an associate physician in the Out-Patient Department of the New York Psychiatric Institute. He was medical director of Craig House before his appointment as assistant chief of the Neuropsychiatric Division of the Veterans Administration in Richmond, Virginia, from which position he comes to Elmcrest Manor.

Dr. Baker was certified a diplomate of the American Board of Psychiatry and Neurology in 1941, is a member of the American Medical Association and the American Psychiatric Association; he has been president of the Psychiatric Association of Dutchess County, New York, and an active member of the Richmond Academy of Medicine and of the Virginia State Medical Association.

Dr. Buchan Named to Medical Post With Prudential

Ronald F. Buchan, former chief of the medical unit of the Bureau of Industrial Hygiene of Connecticut, has been appointed associate medical director of the Prudential Insurance Company of America. Entering the United States Public Health Service in 1943, he was assigned to the Office of the

Surgeon General. Dr. Buchan came to Hartford and organized Connecticut's first full time medical service to industrial firms, a program that involved six companies.

A native of Concord, N. H., Dr. Buchan was graduated from the University of New Hampshire in 1936 and received his medical degree four years later.

Dr. Buchan was recently a faculty member of Yale University School of Medicine as clinical director of its Institute of Occupational Medicine and Hygiene and as associate professor of industrial medicine and associate physician of the institution's Grace-New Haven Community Hospital-University Service.

Dr. Murdock to National Polio Committee

D. Basil O'Connor, president of the National Foundation for the Prevention of Infantile Paralysis, has announced the appointment of Dr. Thomas P. Murdock of Meriden to the Foundation's Committee on Education and Publications. It will be the function of this committee to advise the officers and trustees of the Foundation on matters pertaining to the awarding of grants-in-aid and in the conduct of the various programs bearing upon the entire field of anterior poliomyelitis.

Dr. Spekter Receives Scholarship

Louis Spekter of Hartford, chief of the Division of Crippled Children, State Department of Health, is one of 8 physicians, surgeons and therapists to be awarded a scholarship for specialized training in cerebral palsy by the National Society for Crippled Children and Adults, Inc. This is the first national scholarship program established to meet the challenge of a crippling condition that disables some half million Americans, the Society stated.

Lawrence J. Linck, the Society's executive director, revealed that the scholarships were made possible under the first of six $5,000 yearly grants from Alpha Chi Omega, national women's sorority, which has adopted help to the cerebral palsied as its major national altruistic project. The scholarships will help meet the acute shortage of specialists trained in cerebral palsy, a disability of muscular control which results from damage to control centers in the brain.

The scholarships cover study at the Children's Rehabilitation Institute, Cockeysville, Md., under supervision of the Institute's director, Dr. Winthrop M. Phelps. Dr. Phelps, internationally recognized authority on cerebral palsy, is also president of the American Academy for Cerebral Palsy and chairman of the National Society's Medical Advisory Council on Cerebral Palsy.

The National Society, whose services to all types of handicapped persons is made possible by the annual sale of Easter Seals, is the only agency conducting a nation-wide program on behalf of the cerebral palsied. The recipients of the new scholarships will assist the Society's 2,000 state and local affiliates in expanding cerebral palsy facilities and research through hospital diagnostic and treatment clinics, nursery schools for cerebral palsied children, treatment centers, and special education and recreation projects.

Dr. Creadick on State Fact Finding Committee

Dr. A. Nowell Creadick of New Haven, chairman of the Commission on the Care of the Chronically Ill, Aged and Infirm, is a member of the special committee appointed by the late Governor McConaughy to study hospital financial operations in Connecticut. Through this committee the State aims to secure its own facts about costs, rates and grants of the 32 state-aided hospitals. A complete picture of hospital financial operations should be completed by the time the 1949 General Assembly convenes. The study is being conducted with the cooperation of the American Hospital Association committee headed by Dr. Albert Snoke of New Haven.

Dr. William B. Smith Promoted

Lieutenant Colonel William B. Smith of Wethersfield has been promoted to Colonel, Medical Corps, and assigned to Headquarters Detachment of the Connecticut National Guard.

Colonel Smith has completed more than 25 years military service. A veteran of World War I, he served as a private in the medical corps in France. After his discharge he entered Lehigh University and later transferred to the University of Pennsylvania School of Medicine where he received his M.D. degree in 1922.

He entered the CNG in 1924 as a first lieutenant in the 118th Observation Squadron. His service in the Guard continued until 1940 when he was inducted into federal service as medical officer, head-

quarters, Selective Service, with the rank of major.

After being relieved from active duty, Colonel Smith rejoined the National Guard. He is now surgeon general of the state and a member of the Governor's staff.

Chest Physicians Re-elect Dr. Gibson

Cole B. Gibson, Meriden, was re-elected Governor of the American College of Chest Physicians for the State of Connecticut at the 14th Annual Meeting of the College held in Chicago, Illinois, June 17-20.

William H. Glass, Hartford, was admitted to Fellowship in the College in the class of 1948 and received his Fellowship Certificate.

Fifty-two candidates took their oral and written examinations for Fellowship in the College on June 17 at the annual meeting.

Physicians from 43 states, the District of Columbia, Alaska, Hawaii, Puerto Rico, the Virgin Islands, and 22 other countries, attended the meeting making a total registration of 785. The other countries represented at the meeting were: Argentina, Australia, Brazil, Canada, Chile, China, Cuba, Ecuador, England, France, Guatemala, India, Iraq, Ireland, Korea, Mexico, New Zealand, Pakistan, Peru, South Africa, Spain and Venezuela.

Physicians Address Pharmacists

At the 72nd anniversary session of the Connecticut Pharmaceutical Association held in Hartford in June, Benjamin V. White of Hartford addressed the gathering on "The Physician, the Patient, and the Pharmacist." Samuel A. Schuyler, chief medical officer of the VA in Hartford, spoke on "Veterans' Medical Care," John H. Foster of Waterbury, on "Narcotics," and Colonel W. B. Smith of Wethersfield, on "Dispensing of Pharmaceuticals by Physicians." Barnett Greenhouse of New Haven, chairman of the Joint Conference Committee, was the moderator at an open forum held the first afternoon.

Society Sponsors Second Health Conference

Suitable housing for the chronically ill and aged, and adequate facilities for their rehabilitation are two major problems which must be solved for the welfare of Connecticut's 250,000 residents over 60 years of age.

The problems were discussed by Dr. Joseph H. Howard, Bridgeport, chairman of the State Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm in a talk before approximately 200 rural residents and community leaders at the second Rural Health Conference sponsored by the State Medical Society. The conference was held at the University of Connecticut August 11 as a feature of the University's annual Farm and Home Week.

"There is no reason why many of these people should be sitting in wheel chairs when they could be walking about doing something," Dr. Howard declared in outlining the rehabilitation measures now being developed by the Commission. At the State Veterans' Hospital in Rocky Hill, where a medical center for rehabilitation of chronically ill male patients has been established, outstanding results have already been achieved, he explained.

Plans are underway for incorporation of a similar center for women patients at the New Britain General Hospital, and additional facilities throughout the state are also being studied by the Commission.

Emphasizing the importance of proper housing for aged dependents who are not seriously ill, the Commission chairman outlined the considerations necessary in solving this problem. It is fundamental that husbands and wives in this group should not be separated, and that individuals should not be housed at a distance remote from their relatives and friends. These factors may influence future plans toward the development of the cottage type of residence, he said, and explained that such a plan would call for the establishment of cottage colonies in several sections of the state. As an indication of the serious lack of proper housing for the aged, Dr. Howard told his audience that approximately 600 mildly confused aged persons are now in state mental institutions not because of needed treatment but because no other living accommodations are available.

Speaking on the national aspects of rural health, Mrs. Charles Sewell, Chicago, director of the Associated Women of the American Farm Bureau Federation, declared that any extensive government plan for medical care would be doomed to failure in rural areas.

Although the American Farm Bureau Federation has favored legislation providing reasonable extension of government authority in the field of public health, "such legislation should safeguard the rights of the states to develop their own programs to meet their own local needs," Mrs. Sewell said.

She recommended a plan of action for farm communities as a key for development of better rural health facilities and preservation of the principle of self-help. The first step in community action should be a meeting of interested people, farm organizations, extension services, civic clubs, school authorities, churchmen, and nurses with county medical and dental societies and public health departments to develop answers to three pressing questions: "How shall the sick be helped?—How shall the doctor, dentist, nurse, and hospital be paid?—What can we do in an educational campaign to institute preventive measures that will lead to better health?"

As a second step in the program, Mrs. Sewell recommended a survey of rural health conditions and needs, this to be followed by the third step of enlisting public support through educational and promotional techniques.

"America has her greatest stake in a healthful citizenry," she declared. "Her economic and cultural advancement, as well as military strength for national defense are inextricably woven together. Today we must meet this great challenge with the best we have, and solve the problems by application of the time honored American doctrines of self-help and individual responsibility. We can no longer say there is no problem, and dismiss it with a shrug of indifference. If we do not present a positive approach and apply what we know and what we have, there are those among us who, restless and discontented, will seek to fasten upon us a system of regimentation and compulsion foreign to American ideas and ideals. The stake is tremendous."

The speakers were introduced by Dr. Norman H. Gardner, East Hampton, chairman of the Society's Committee on Rural Medical Service. Members of the committee are Dr. David H. Bates, Putnam; Dr. Gaert S. Gudernatch, Sharon; Dr. William H. Upson, Suffield; and Dr. James F. Ferguson, Wallingford.

Announcement

The CONNECTICUT STATE MEDICAL SOCIETY has made arrangements to secure, through its JOURNAL, *Medicine of the Year* for those of its members who wish to subscribe. *Medicine of the Year* is an annual review of medical progress which will appear as a supplement to the JOURNAL early in 1949. It will be a descriptive and analytical account of progress in medical science and practice during the preceding year, presented in a practical, useful, and informative manner, particularly as they relate to the everyday practice of general medicine and the specialties.

The editorial management is under the direction of Dr. John B. Youmans, dean, College of Medicine, University of Illinois. The principal contributors and their subjects are the following well known medical educators and writers:

Internal Medicine—Dr. Hugh J. Morgan, professor of medicine, Vanderbilt University, Nashville, Tennessee.

Obstetrics—Dr. Frank Whitacre, professor of obstetrics and gynecology, Memphis, Tennessee.

Pediatrics—Dr. Henry G. Poncher, professor of pediatrics, University of Illinois, Chicago, Ill.

Surgery—Dr. Warren H. Cole, professor of surgery, University of Illinois, Chicago, Illinois.

These men will have associated with them an equally competent and distinguished group of authors in special fields.

This annual review of medical progress is being offered to members of state medical societies and subscribers to state medical journals. The subscription price is $1.60 annually, of which your Society will retain a portion to defray any costs associated with the announcement of this service and the handling of the subscriptions, or for such other purposes as the Society wishes. In order to secure this service, subscriptions from approximately one-third of our members and subscribers is required. Because of the short time available, subscriptions must be entered promptly. *Do not delay.* Send in the coupon below, or write directly, sending check or money order. If an insufficient number of subscriptions is obtained, no obligation will be incurred and your money will be refunded. *Act now.*

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Report on the First Meeting of the Connecticut Committee on Foods, Drugs, Cosmetics and Devices held at New Haven on June 22, 1948

The Connecticut State Medical Society has been requested to approve the principles set forth in this report

This committee was organized at the invitation of the Connecticut State Medical Society and the Connecticut Pharmaceutical Association. The general purposes of the organization are shown in the following quotation from the original letter of invitation to the participating agencies:

"In a very general sort of way, this Connecticut Committee would serve on a local scale the same function as is served on a national scale by the American Medical Association Council, the Council of the American Pharmaceutical Association, and other national groups organized along the same lines.

"The purpose of this Committee would be to supply state agencies and other interested groups with a disinterested opinion as to the therapeutic status of various remedies or other preparations which might influence health.

"The Committee would render confidential statements on the merits of preparations to well authenticated agencies or groups such as the State Board of Health, or to their officers. The majority of such statements would be based on experience, either personal or solicited. Occasionally chemical or pharmacological testing would be required. Therefore, the Committee could add members on a temporary basis to cover specific situations as they arise.

"The official state agencies have already pointed out that they would welcome the formation of such a Committee to supplement their efforts. Already having received this endorsement, it is our proposal to organize this group so that it will become the semi-official agent of all the professional societies involved."

The participating societies and institutions and their representatives at the first meeting were as follows:

College of Pharmacy, New Haven—Dean H. G. Hewitt.

Connecticut Agricultural Experiment Station—Dr. Harry J. Fisher.

Connecticut Pharmaceutical Association—Prof. Nicholas W. Fenney.

Connecticut State Dental Society—(Dr. Englander was unable to atend).

Connecticut State Medical Society—Dr. Gray Carter.

Connecticut State Veterinary Society—Dr. E. H. Patchen.

University of Connecticut—Dr. Stanley E. Wedberg.

Yale University School of Medicine—Dr. William T. Salter.

The following state enforcement agencies were also represented:

Food and Drug Commission—Mr. Herbert Plank.

State Department of Health—Dr. Eugene E. Lamoureux.

The first meeting was confiend to a rather general discussion, no official requests for opinions on specific products having been received. It was agreed that detailed rules and procedures must be left to be developed on the basis of experience in handling specific questions presented to the committee.

The following principles were decided on at this time:

(1) Because requests for opinions will usually come from the enforcing agencies, these agencies will not have membership on the committee, but will be invited to send representatives to sit in at meetings of the committee. The following agencies are asked to send such representatives: the Food and Drug Commission, the Pharmacy Commission and the State Department of Health.

(2) The primary concern of the committee is the welfare of the public. Ordinarily, opinions will be rendered only on the request of an official enforcing agency or one of the sponsoring societies and institutions. In rare instances of widespread danger to the public the committee may act spontaneously.

(3) The committee will not directly endorse or express disapproval of a product except as this may be necessary for the protection of the public.

(4) It is not the intention of the committee to duplicate the work of the national councils of the professional societies, but rather to adapt and amplify this work as may be necessary to meet local problems arising in Connecticut.

(5) The actual minutes of the committee will be confidential, but a report on the actions of the committee will be sent to each society, institution and agency by the secretary after each meeting.

(6) All public statements on the work of the committee will be made by the secretary only.

The committee decided that meetings would be held at New Haven; the next meeting would be about the middle of September.

Harry J. Fisher, PH.D., Secretary

Repackaging Drug Products

The Joint Conference Committee of the State Medical Society and the Connecticut Pharmaceutical Association voted at a meeting on July 27 to endorse a proposal concerning repackaging of drug products. The proposal is contained in an article written by William T. Cadwell, New Haven pharmacist, member of the Fair Trade Policy and Planning Committee of the National Association of Retail Druggists and former president of the Con-

ecticut Pharmaceutical Association. It was pub-shed in the July issue of the *Connecticut Pharma-ist* and is herewith reprinted in full:

N Answer to One of Our Inventory Problems?

In the recent past we have all seen our prescription nventories rise to an all time high, which, no oubt, accounts for the fact that our prescription epartments do not produce the profits of former ears.

The troublemaker is, of course, the daily increase f specialties, but, like it or not, they are here to ay so let's try to improve an already serious con-ition.

On the shelves of the Rx department in every one f your stores, you will find countless bottles, vials nd boxes of all various kinds of pills, tablets, cap-ules, etc., which you purchased at some previous ate (and paid for) to accommodate the prescription f a physician, who, relaxing after the daily barrage f detail men, wrote for a certain medication (usual-y the last one detailed). Naturally, the doctor could ot be expected to remember the count packings of ll the new preparations, so he wrote for, say 10, o, 30, or 40, whichever number struck his fancy.

Assuming that we had the specified preparation n hand we proceed to dispense the required num-er called for and then discover that the profit vhich we should have in the cash register is not here but instead is still on the shelf in the form of he 10, 20, or 30 tablets, etc., left over from the riginal package and waiting for another prescrip-ion for the same medication (you hope).

With this new age of streamlining and simplifica-ion of everything, I believe that the time has come or the manufacturers of drug specialties to revise he package count of their preparations. The reason or the above "leftovers" is no doubt due to the aulty practise of the manufacturers in not putting ut a uniform size package. A look at your shelves vill show you items packed in 10s and multiples of up to 100. I have asked many times why this is so ut as yet have been unable to receive an intelligent nswer for this myriad of packings.

Why not inaugurate a new system and have these roublesome specialties put on the market in pack-ges of 25s, 100s, and 1000s.

Among the advantages to be gained by this new roposed packing, the following may be mentioned:

A physician does not write for an odd number of c's to a finished prescription. He has learned that the proper quantities to write for are 30 cc or multiples thereof and it would be a simple matter to educate him as to the sizes of the new packages. With this information he could write for an original package of, say 25, in cases where he is trying out a new item. If the medication works satisfactorily and he desires its continuation he would increase the package to the next size of, say 100, with the resulting price saving to the patient.

The wholesaler would be able to operate more efficiently due to a smaller number of sizes to be stocked and therefore a reduced inventory.

The benefits to the retailer are so numerous and well known to all of us that it is useless for me to mention them here.

Think this over and let me have your comments.

Regulations for Supplies to Welfare Beneficiaries

On and after August 1, 1948 all drugs and sick room supplies procured for beneficiaries of the Office of Commissioner of Welfare will be procured in accordance with the recent agreement between the Connecticut Pharmaceutical Association and the Office of Commissioner of Welfare. These beneficiaries include:

1. Division of Child Welfare.

2. Division of Public Assistance. Old Age Assistance. Aid to dependent children. Aid to the blind.

3. Division of State Aid and Collections.

These regulations provide in part the following:

Note: Nothing in these regulations shall be construed as preventing the procurement or administration of any drug or sick room supplies which shall be considered necessary by the attending practitioner to sustain the life of the patient.

1. *On prescription only.* Drugs and sick room supplies will be paid for by the Office of Commissioner of Welfare only when they are prescribed or ordered by a physician on his prescription blank.

2. *Supplies on prescription.* Items, such as a "hot water bottle," which are ordinarily not prescription items will be ordered (to facilitate the billing under this program) on a prescription blank.

3. *Prescription presented as usual.* Prescription of the attending physician will be presented to any pharmacy by the patient or his responsible agent.

4. *Refills of prescriptions.* Prescriptions may be refilled *once* at the discretion of the prescribing

physician. Further use of the same medication will require that another prescription be written.

The cooperation of all physicians caring for beneficiaries of the Office of Commissioner of Welfare is required to insure the success of this program. The program is in accord with the policy of the Office of Commissioner of Welfare that it will provide complete medical service for its beneficiaries as similar as possible to private medical services.

Since the medical program, however, represents an expenditure of public funds, the physician is respectfully requested to give due weight to the following considerations in the writing of prescriptions:

A. Manufacturers' names should not be placed on the prescription for a drug unless in the opinion of the prescribing physician the specific drug of that manufacturer is the only one which will adequately meet the needs of the patient.

B. When a long series of injections of hormones or other injectibles is contemplated, a statement of the extent of the proposed treatment should be submitted for prior authorization.

C. Prescriptions should order amounts of drugs which will most satisfactorily meet the needs of the condition, and, in the instance of extended therapy, usually cover a month's supply.

D. Since beneficiaries of the Division of Public Assistance are provided with a nominal sum monthly for the purchase of such minor medical supplies as bandages, adhesive tape, aspirin, and mercurochrome, such items will not properly be written for as prescriptions.

Any questions regarding the above regulations or any other aspects of the medical care program should be referred to the medical director.

W. H. Horton, M.D., Medical Director,
Office of State Commissioner of Welfare

Panel of Specialists to Visit Clinics

Through a plan set up by the Association of Tumor Clinics and the Medical Advisory Committee of the Society, a panel of cancer specialists will carry their skill and experience to tumor clinics throughout the State. The clinics will specify the specialists they wish to have make the visit.

The services of the consultant will be at the disposal of the clinic for help with particular diagnosis and treatment problems, or for discussion of general principles in the specialist's field. The following constitute the panel of consultants:

Surgeons: Dr. Samuel C. Harvey, Dr. Edward J. Ottenheimer, Dr. Ashley W. Oughterson, Dr. Max Taffel, Dr. John O. Vieta and Dr. N. William Wawro.

Gynecologists: Dr. Carl Johnson, Dr. Louis F. Middlebrook and Dr. Arthur Morse.

Urologists: Dr. Phillip Cornwall and Dr. Chris Neuswanger.

Radiologists: Dr. Gilbert Heublein, Dr. Arnold H. Janzen, Dr. Ralph Ogden, Dr. Berkley Parmelee and Dr. Hugh Wilson.

Blue Cross Offers New Service to Group Members

To accommodate Blue Cross Participating Firms who wish a higher credit for room service in member hospitals, Connecticut Blue Cross is now offering an Optional Rider to the Blue Cross contract, according to announcement by Robert Parnall, general manager of the non profit hospital plan. The Optional Rider provides an additional credit of $3 per day against hospital room charges during the basic 21-day full benefit period.

Additional monthly dues for the Optional Rider are: subscriber only, 30¢; subscriber and enrolled wife or husband, 60¢; subscriber and enrolled family, 90¢.

Parnall emphasized that this new service is strictly optional with each Blue Cross group and that it does not affect any of the other Blue Cross benefits, including the full provision of special services regardless of hospital charges.

"Some groups have asked for the Rider to help meet increased hospital room charges," he said. "They expect to pay more money for this added coverage. Others wish to continue the present Blue Cross program without any increase in dues. Hence, adoption of the Rider is entirely optional with each participating firm."

To install the Rider, at least a majority of the Blue Cross subscribers in any one group must apply for it, Parnall stated. The subscriber who elects the Rider can continue it only so long as he is employed by a Blue Cross Participating Firm which has a Rider group.

Parnall said that the Optional Rider has been fully approved by the State Insurance Commissioner.

FEARFUL ARE THE UNINFORMED

Vague fears are born when people are not informed concerning medical affairs.

These fears can generate public antagonism when they are permitted to grow.

Medical public relations must consistently furnish people with sufficient information to dispel these fears.

Public Information Creates Good Will

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, John G. Frothingham, New Canaan
Hartford County, James R. Cullen, Hartford
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Richard F. Grant, Cromwell
New London County, Edmund L. Douglass, *Chairman*
Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, William Schneider, Rockville
Windham County, William S. Maurer, Willimantic



PUBLIC AFFAIRS

NEWS FROM WASHINGTON

Health Emergency Planning Unit

Establishment of a Health Emergency Planning unit in the Public Health Service was announced recently by Federal Security Administrator Oscar R. Ewing.

Dr. Norvin C. Kiefer, senior surgeon, will direct the unit with the assistance of Gordon E. McCallum, sanitary engineer. The unit will cooperate with the National Security Resources Board, the Office of Civil Defense Planning of the National Military Establishment, the Military Services, and State Health Departments, as well as professional and voluntary organizations, to plan a coordinated program for safeguarding public health during a national emergency. Existing facilities within the Public Health Service will be surveyed in order that those with significance during a national emergency can be readily integrated with civil defense plans.

The new unit will also draw plans for more comprehensive public health catastrophe services to be offered in response to peace time emergency requests from States. The Public Health Service has, for some time, rendered such services through its Communicable Disease Center. These efforts have been concentrated primarily on sanitary engineering problems, such as control of rodent and insect carriers of disease, and protecting the safety of water and food during major disasters.

The New Draft Law

The provision carried by each bill that would have required all physicians up to the age of 45 to register was deleted. This clause was stricken out because physicians from all over the United States, and many other citizens as well, objected to the registration of physicians in higher age groups than was required of other citizens. The profession and the public both realize that medical care is an essential in any army and especially in an American army, and the consensus was that a sufficient number of physicians would be willing to volunteer as the Armed Services might need them.

The authors of the original bills defended their 45 year requirement by stating that not all would be called immediately, but only those who had not served a minimum of 2 years as commissioned officers in the Medical Corps of the Armed Services. Under the law as enacted, those physicians who have not reached their 26th birthday may be drafted unless they apply for commissions. Congressmen agreed that physicians who were helped by the Government in securing their medical education, either by taking one of the offered courses or because of deferment, should be the first to contribute their services, and the House of Delegates of the American Medical Association at its recent meeting adopted resolutions to the same effect.

The conditions to which this law addresses itself are unique for America. We are not at war, but the tense conditions existing in Europe may at any time precipitate a war. It is altogether possible that the enlargement of our defense forces may persist for years, and physicians to whom a military career may appeal can now have an opportunity of so engaging themselves.

Another law passed by Congress, which the President signed recently, provides that Reserve Officers of any of the Armed Forces who have completed 20 or more years of acceptable membership may retire with benefits after they reach the age of 60. Retirement pay will be computed at 2½ per cent of base pay for the highest rank held multiplied by the number of years on active duty, plus ½ of 1 per

cent of the same base pay multiplied by the number of years on inactive status. The pension may amount to as much as 75 per cent of the highest active duty pay drawn by the person receiving the pension. The need and fairness of this action have long been felt by those who have patriotically filled our Reserve Corps.

Civil Defense Plans

The medical advisory committee to the Office of Civil Defense Planning under the chairmanship of Dr. Perrin H. Long has turned in a master plan for the utilization of physicians, dentists, nurses and allied professionals in the event of a sudden attack.

President Sensenich of AMA has been in conference with military medical leaders to solve the problem of securing the necessary physicians for the armed forces.

THE DOCTOR'S OFFICE

Robert F. Buckman has opened his office for the practice of medicine at 157 Gulf Street, Milford.

Anthony Cipriano, M.D., announces the opening of an office for the practice of internal medicine at 174 Bradley Street, New Haven.

George H. Dickinson, Jr., M.D., announces the opening of an office for general practice at 119 West Main Street, Meriden.

Walter Raymond James, M.D., formerly of Los Angeles, California, is now associated with Dr. William G. Ames of Essex.

Ralph H. Jenkins, M.D., announces the association of Michael S. Hovenanian, M.D., in the practice of urology at 59 College Street and 789 Howard Avenue, New Haven.

Vincent F. Longo, M.D., former resident physician at Bristol Hospital, announces the opening of an office at 205 Central Street, Forestville.

The New Britain Medical Group announces the association of William T. Livingston, M.D., with Bliss B. Clark, M.D., 32 Grove Hill, New Britain. Practice limited to surgery.

S. J. Silbermann, M.D., announces the opening of an office for the practice of neurosurgery and neurology at 179 Allyn Street, Hartford.

Benjamin Wiesel, M.D., announces the opening of an office for the practice of psychiatry at 56 Garden Street, Hartford.

Metopon Hydrochloride Now Available by Prescription

The Treasury Department announced on June 21, 1948 that Metopon has been released to qualified wholesale drug dealers, hospitals, druggists and practitioners. Subject to compliance with Federal narcotic laws and regulations, physicians may now make the drug available to patients on prescriptions.

The limited use of Metopon Hydrochloride (Methyldihydromorphinone hydrochloride) for the relief of pain in cancer cases was originally recommended by the Drug Addiction Committee of the National Research Council. This Committee with the cooperation of the American Cancer Society supervised the distribution of the drug.

In the past Metopon could be obtained only by using a regular official Narcotic Order Form accompanied by a signed statement supplying information as to the number of patients to be treated and the diagnosis in each case. Each physician was sent a record card which had to be filled out and returned to the National Research Council.

A full description of this drug and its uses was published in *The Journal* (XI, 11, 931, Nov. 1947).

Plans Raise Income Ceilings

With the approval of their respective House of Delegates, two Blue Shield plans were authorized recently to increase the income ceilings under which full service benefits are provided for subscribers.

Medical-Surgical Plan of New Jersey was authorized to establish its income ceiling at $5,000 for all subscribers, regardless of marital status. At the same time an increased fee schedule for payment to physicians was approved, the combination of changes requiring an upward adjustment in subscription rates.

California Physicians' Service secured approval for hiking its income ceilings to $3,000 for single persons and $4,000 for families, without any immediate change in fee schedules or subscriber dues.

In both plans participating physicians have agreed to accept the established fee schedule as full payment for services rendered to subscribers whose income falls below the income level described above, being privileged to make their usual charges in all other cases while accepting the plan's payment as a credit against the total charge.

STERILTY CONFERENCE — JUNE 21-22 — CHICAGO

The 4th annual conference of the American Society for the Study of Sterility was held in the Congress Hotel in Chicago on June 21 and 22. The roster of the Society contains about 50 active members and approximately 40 associate members. The fact that each session was attended by more than 300 physicians indicates that there is a growing increase in interest in the problems of infertility. This young organization meets annually in conjunction with the annual session of the AMA. In addition two or three sectional meetings are held during the year. The attendance at all the conferences of the Society is on the increase and as one meets in New York, Chicago, Denver, Los Angeles, one finds the same small group of earnest workers at each gathering, a nucleus for the larger group.

In all 25 papers were presented during two long days of complete disregard for the ischial tuberosities. Only a few can be reviewed here. Laman A. Gray of Louisville has been using equine gonadotropin in a series of infertile males and reports good results. He wasn't too convincing, especially after C. W. Charny of Philadelphia stated that only 20 per cent of men have endocrine dysfunction producing impaired fertility. "The Pattern of Uterine Motility and Its Importance in Spermigration" by William Bickers of Richmond reported a study of the path of myometrial contractions by means of an inflated intrauterine balloon connected to a kymograph. This method apparently has some prognostic value in that individuals whose kymograph tracing was irregular rarely were found to produce offspring. "Ovulation Timing" by Edmond J. Farris of Philadelphia was a well prepared study of the time of human ovulation and included a film demonstration of the performance of the test. In 46 couples all conceptions occurred between cycle days 8 and 19, with 60 per cent of the conceptions taking place on cycle days 11, 12 and 13.

A scholarly dissertation on the "Physiology of Spermatozoa" by John MacLeod, PH.D., New York City, discussed the behaviour of human spermatozoa in Ringer's solution, not in seminal fluid. This was done under the following headings: (1) Observations on epididymal spermatozoa; (2) Behaviour in seminal fluid and factors therein affecting duration of motile activity; (3) The metabolic behaviour in relation to specific substrates and enzyme systems involved in motile activity; (4) Their behaviour in relation to variations in their osmotic environment and the effect of certain ions.

Fred A. Simmons of Boston presented a paper on "Ovulation Timing By Basal Body Temperature Curves." This provoked considerable discussion of a practical nature. For example, Pendleton Tompkins of San Francisco demonstrated the value of the basal body temperature chart in prognosticating an abortion. Another speaker showed evidence that progesterone prevented this threatened abortion and produced a temperature curve returning to normal. Boris B. Rubenstein of Chicago uses both estrogen and progesterone to prevent abortion. He has found that after the first trimester the basal body temperature chart may drop and the pregnancy proceed normally.

Karl J. Karnaky of Houston, Texas, spoke on "The Dosage of Stilboestrol in the Treatment of the Relative Sterility of Abortions and Premature Labor." Most gynecologists are familiar with his practice of using 25 mg. t. i. d. to stop abortion and 25 to 100 mg. every 15 minutes until bleeding stops in case of threatened abortion. Habitual abortees receive 10 to 25 mg. of stilboestrol every morning at his hands. In discussing Dr. Karnaky's paper, A. R. Abarbanel of Beverly Hills, California, emphasized the fact that the salvage of threatened abortion is higher using 25 mg. of progesterone in addition to stilboestrol.

"Conceivable Psychogenic Aspects in Sterility" by Earle M. Marsh of San Francisco was a very practical discussion of the psychosomatic approach to sterility problems and the possibility of psychotherapy in such cases. He stressed that sterility may be a symptom of generalized neurosis. The important therapeutic role of the non psychiatric trained physician was emphasized.

These 25 papers came from the fields of anatomy, physiology, biochemistry, endocrinology, neurology, surgery, and psychiatry. They represented original work, in some instances pioneer work. Discussion was lively and intelligent. Much credit goes to the former secretary-treasurer, John O. Haman of San Francisco, and to the retiring president, Walter W. Williams of Springfield for their contagious interest in this field. Dr. Williams was elected secretary-treasurer for the year 1948-1949. The new president is Lyman Mason of Denver, an active member of the Colorado State Medical Society and during the recent war editor of *Rocky Mountain Medical Journal.*

Peripateticus

First International Poliomyelitis Conference

The United States acted as host to medical leaders rom about 60 foreign governments during the 6- lay conference held in New York City in July. In ddition to these official delegates there were present epresentatives of invited universities, societies and cientific and philanthropic organizations interested n research and treatments of virus diseases as well s physicians and other scientific and professional ersons qualified by recognized standards.

The delegates were welcomed by D. Basil O'Con- or, president of the National Foundation. Foreign lelegates were introduced by Morris Fishbein, editor of the *Journal of the American Medical Association.*

The session included panel discussions and pre- entation of medical and scientific papers on polio- nyelitis. There were demonstrations of scientific pparatus used in research and treatment of the lisease, medical and scientific exhibits, receptions, ntertainment and excursions.

John R. Paul, professor of preventive medicine t Yale University School of Medicine, reported the possibility that the properties of poliomyelitis virus may change in time. Dr. Paul declared that in carry- ing the Lansing (human) strain of polio virus through mice, it may become "contaminated" with a polio-like virus which occurs spontaneously in mice. At least two neurotropic viruses have been found in mice, he noted, but these do not "take" in monkeys and presumably are incapable of infecting humans. From this, Dr. Paul believes, indications can be gained on the evolution of polio virus.

Dr. Paul outlined 5 general characteristics of the polio virus: preference for gray matter of the central nervous system; it is recoverable from the intestinal tract of the infected host; it is one of the smallest known; it attacks man alone in nature and the primates and three types of rodents experimentally; and it resists ether, a characteristic which enables the researcher to rid virus containing substances of other contaminants so that more complete studies can be accomplished.

Considerable discussion arose over the cost of the Sister Kenny treatment. Professor Herbert J. Seddon of Oxford University made the statement that the Kenny treatment was several times more expensive than the so-called orthodox treatment. Sister Kenny challenged this statement. Dr. Fishbein attempted to reconcile both factions by saying that it was not possible to compare the expenses of different treatments, because their variations by physicians and in various institutions were too great and because there was no standard by which to measure them.

Physical activity after the onset of the disease was felt to contribute importantly to the severity of the paralysis. William T. Green, professor of orthopedic surgery at Harvard Medical School, said too much emphasis has been placed on minutiae in the management of the after effects of polio rather than on fundamental considerations. "No treatment," said Dr. Green, "is good a priori; it may be good or bad depending upon the particular patient at a particular time. Means must be subordinated to the end."

A message was read from President Truman. At the dinner meeting Frank R. Ober, professor of orthopedic surgery at Harvard Medical School, and R. L. Sensenich, president of the American Medical Association, were among the speakers. Several physicians from Connecticut attended the conference.

Cancer Society Raises Over $1 Million

The Connecticut Cancer Society's 1948 campaign closed August 31 with more than $358,000 in contributions, bringing total cancer funds raised in the state since 1945 to more than one million dollars.

Although contributions have continued to climb upward, the rate of increase has been exceeded each year by the expansion of facilities to meet public needs insofar as funds permit. The Society now operates 14 cancer information centers throughout the state, in addition to performing numerous other functions.

State Educational Chairman at National Cancer Training Sessions

Several Connecticut delegates were among the large gathering of representatives from all parts of the country, attending the National Cancer Training School, conducted in New York by the American Cancer Society, from June 10 to June 30. A featured speaker during discussions on education was Dr. Charles C. Wilson, professor of public health education at Yale and chairman of the Society's State Education Committee.

BCG VACCINATION

Vaccination with BCG does not provide complete protection against tuberculosis and, until further controlled studies are conducted, cannot be recommended for the general population. However, since BCG appears to provide some degree of protection, it is recommended for members of groups constantly exposed to tuberculosis if they have a negative reaction to the tuberculin test.

These conclusions are contained in a statement of policy adopted by the Executive Committee of the American Trudeau Society, Medical Section of the National Tuberculosis Association, and published in the March issue of the *NTA Bulletin*. This is the first official statement by the ATS on BCG.

Dr. H. McLeod Riggins of New York, N. Y., chairman of the ATS Chemotherapy Committee, states that BCG vaccination, developed by Calmette and Guerin from a non virulent strain of tubercle bacilli, causes a primary tuberculosis infection. As a result of this infection the body increases its resistance to the disease, inducing an artificial immunity of varying degree. A positive reaction to the tuberculin test, according to Dr. Riggins, indicates that a person has had a primary tuberculosis infection and his body has built up a degree of acquired immunity. Persons having a positive tuberculin test reaction probably do not benefit from vaccination with BCG, he said.

The statement emphasizes that further studies are necessary to determine the true value of BCG and points out that the vaccine cannot be regarded as a substitute for approved public health measures to protect the public from tuberculosis. Until additional information is obtained, vaccination of the general population cannot be recommended except for carefully controlled investigative programs, several of which are now under way. These programs, the statement suggests, are usually best carried out under the auspices of official agencies, such as the U. S. Public Health Service, state and municipal health departments and other especially qualified groups.

Although studies thus far made indicate that the incidence of tuberculosis may be reduced when groups likely to develop the disease because of unusual exposure to tuberculosis are vaccinated, the statement points out that the degree of protection afforded the individual is not complete and the duration of relative immunity is not known.

BCG vaccination is recommended for the following groups if they are subjected to more than ordinary exposure to tuberculosis: doctors, medical students and nurses; hospital and laboratory personnel whose work brings them in contact with the bacillus of tuberculosis; individuals who are unavoidably exposed to tuberculosis in the home, and patients and employees of mental hospitals, prisons and other custodial institutions among whom the incidence of tuberculosis is known to be high.

Even with these groups, the statement warns against placing complete reliance on BCG for protection and points out that proper precautions should be taken to minimize or prevent "undue hazardous exposure of hospital patients and personnel and members of a household if an infectious patient is under treatment in the home."

While the vaccine, when prepared under ideal conditions and administered to tuberculin negative persons by approved techniques, may be considered harmless, the statement does not advocate that BCG be made available for general distribution in the United States at present because: (1) the most effective strain of BCG has not been determined nor has satisfactory standardization of the vaccine been achieved, (2) the best qualified experts have not agreed as to the most effective vaccination procedure to employ and (3) fully satisfactory arrangements have not been perfected for transportation and storage of the vaccine.

It is further recommended that the vaccine be prepared only in laboratories especially devoted to this task and where virulent tubercle bacilli are not cultivated or handled and where all possible precautions are exercised to assure safety of the product.

"Fortunately great advances have been achieved during recent years in the development of diagnostic methods applicable on a mass scale and there have been equally great improvements in the surgical and medical treatment of tuberculosis," the statement concludes. "The expansion of modern diagnostic and therapeutic facilities is required at this time to make full use of these new methods which can accomplish further dramatic reduction of tuber-

culosis mortality and morbidity rates in the United States.

"It is to be emphasized that BCG vaccination must not be regarded as a substitute for approved hygienic measures or for public health practices designed to prevent or minimize tuberculous infection and disease. Vaccination should be regarded as only one of many procedures to be used in tuberculosis control. Vaccination seems unwarranted: (a) in areas in which the tuberculosis mortality rate is extremly low and (b) in localities in which the tuberculin test is of especial value as a differential diagnostic procedure."

Sickness "Pays" in Rhode Island

A woman employee at a large industrial plant in Rhode Island injured her back while working. Her weekly wage was $30, of which she took home $27 following tax and benefit payroll deductions. During the period of her work-incurred disability she received total compensation of $47 a week, exempt from all deductions.

Elizabeth K. Wilson, an actuary who has studied compulsory health insurance for 17 years, cites this example as one of the growing number of absurdities in Rhode Island's compulsory sickness benefit plan. Writing in the May 15 issue of the *Christian Science Monitor*, Miss Wilson tells of the difficulties now being encountered by the plan, and concludes that it is erected on a false actuarial base.

Now in its fifth year, the plan authorizes payment of full benefits to all employees, whether or not their wages during periods of illness are customarily paid by their employers. This provision, embodied in an amendment to the law creating the plan, was passed in May 1943.

The amendment makes it possible in many cases for ill or injured workers to receive more money during periods of disability than when they are at work. Consequently, malingering, which Miss Wilson claims to be the chief bugaboo of all health insurance plans, has been on the increase.

Physicians have become involved in this development because the law requires each worker to have a physician's certificate in order to collect benefits. Doctors who have refused to sign certificates, feeling that the worker concerned could perform some other task though temporarily incapacitated for his regular job, have lost patients.

Physicians were further confused when the board administering the plan construed "sickness" liberally, even including pregnancy. Then the board inaugurated medical examinations by staff physicians, and this not only further confused matters but raised considerable resentment. In some cases decisions reached by the staff appeared to discredit the findings of family doctors.

Despite these handicaps, and the obvious over-insurance of some groups, Miss Wilson states the first year's operations ended with a million dollar surplus. However, in December 1945 a crisis began to grow. By the following spring the situation became so critical that a special committee was summoned to investigate. Although powerful labor leaders were members of this committee, it was nevertheless recommended that the law be tightened, and that the total employee contribution of 1½ per cent of wages be allocated to the cash sickness fund. This represented an increase of 50 per cent, since the original law provided that only 1 per cent of wages was to be used for this fund, while the remaining 0.5 per cent was earmarked for unemployment compensation.

A few months following passage of this amendment by the Rhode Island legislature, Congress incorporated the Knowland Act into the Social Security Law. This permitted any state in which workers had contributed to unemployment compensation to divert all funds so accumulated to the purpose of cash sickness benefits. It meant for Rhode Island that its reserve could get a windfall of $28,000,000.

"One would have supposed that this would have been set aside as a protection against epidemics, recessions, and catastrophes."

But "that was not the politicians' idea," Miss Wilson relates. "The dwindling reserve from which payments had previously been made was set aside as the fund for administrative expenses. The bonanza became the source of all benefit payments. The employee contributions were reduced immediately. Limitations as to payment of benefits to retired workers, which had been enacted the previous year, were repealed. The administrative expense limit was set at 6 per cent, a sixfold increase in 5 years."

"This year legislation was proposed to almost double the benefits," the author writes, and points out that "the situation is not actuarially sound."

. The Rhode Island plan covers approximately 300,000 workers. Their cash benefits range from $6.75 to $18 a week whenever they are sick at least 2 weeks annually. No benefits are paid for the first week of illness, but thereafter the payments continue for periods varying from 4 to 20 weeks, depending upon the individual's weekly benefit rate and wage credits. Workers who make $1,800 or more receive the maximum benefit of $18 per week for 20 weeks.

The program is an offshoot of the unemployment compensation system. Following passage of the Federal Social Security Act, the various states enacted employment security legislation. Nine states, including Rhode Island, provided that both workers and employers contribute, but reserves mushroomed to such large proportions that 5 of these states subsequently discontinued employee taxes.

For reasons which have never been explained, Rhode Island labor and political leaders objected to discontinuance of the employee tax. Instead, Governor J. Howard McGrath consulted experts of the Federal Social Security Administration. With their assistance, the State Unemployment Compensation Commission drafted the measure for cash sickness benefits. Introduced in the General Assembly, it was passed in 20 legislative days, express-train speed for this type of legislation, and became law on April 23, 1942. Miss Wilson credits lack of opposition to the fact that workers were already paying 1½ per cent of their wages for unemployment compensation and therefore did not feel that the new sickness benefit plan would cost them anything. Since medical benefits were not mentioned in the legislation, Rhode Island's doctors did not feel that professional medicine could become involved.

But now undesirable effects of the legislation are obvious in several directions. Employers complain of increased absenteeism, many workers find that malingering brings them more money at home than on the job, and physicians have encountered problems which cannot be resolved.

Only one other state, California, has followed Rhode Island's example. It has profited from the mistakes of its predecessor, and its plan is working better. But the author concludes that this experience is of little significance since California has been paying benefits for less than 2 years.

Naval Air Reserve Needs Doctors

The Naval Air Reserve Training Command needs doctors. Doctors who served in the Navy during the past war and who still hold reserve commissions are requested to apply for two weeks annual training duty or up to five months extended duty at Naval Air Stations, it was announced recently by Rear Admiral Richard F. Whitehead, USN, chief of Naval Air Reserve Training.

Naval Reserve Medical Officers who can possibly spare the time, are urged to apply for this duty to help alleviate the work load at those stations which are under-manned. Applications are made via the Commanding Officer of the Air Station to the Commandant of the Naval District concerned. The following Naval Air Stations need assistance: NAS Akron, NAS Atlanta, NAS Columbus, NAS Dallas, NAS Denver, NAS Glenview, NAS Grosse Ile, NAS Los Alamitos, NAS Memphis, NAS Miami, NAS Minneapolis, NAS New Orleans, NAS New York, NAS Oakland, NAS Olathe, NAS Squantum, NAS St. Louis, NAS Willow Grove, NAResTraUnit, Anacostia, D. C., NAResTraUnit, Jacksonville, NAResTraUnit, Norfolk, NAResTraUnit, Seattle, NAResTraUnit, Lakehurst.

ACTIVE DUTY BILLETS

The shortage of Medical Officers in the Naval Air Reserve Training Command has at all times been acute. In general, billets for two Medical Officers of the Naval Reserve of the rank of Comdr. and Lieut. are authorized (with privilege of waiver of rank) on full time active duty.

Medical Officers who request active duty for one year or more are eligible for additional pay of $100 per month over and above regular pay.

Officers qualified in aviation medicine are especially desired. However, Medical Officers on active duty can apply for the five month course at the School of Aviation Medicine at Pensacola, Florida, eventually leading to the designation: Naval Flight Surgeon.

Quarters are available at some stations and Medical Officers in the Naval Air Reserve cannot be transferred without consent.

Naval Reserve Medical Officers who are desirous of this duty or wish to obtain further information should write to: Staff Medical Officer, Naval Air Reserve Training Command, Glenview, Illinois.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*

Egbert M. Andrews, Hartford
Joseph J. Bruno, New Haven
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Vocational Training of Disabled Veterans

Disabled veterans may continue their training nder the Vocational Rehabilitation Act (Public aw 16) after Veterans Administration suspends heir disability compensation for failure to report or a physical re-examination.

However, during the suspension period, they vill forfeit the special subsistence and dependency llowances provided for disabled trainees.

During that period, they will receive only the ubsistence allowances payable to non disabled vetrans training under the GI bill.

VA's ruling is based on the refusal of a Public aw 16 trainee to report for a physical re-examinaion VA ordered for disability rating purposes.

The decision held that the veteran's refusal to ubmit to re-examination does not remove his ligibility to complete his training.

Regardless of the findings of the re-examination, he veteran would be entitled to complete his reabilitation since he originally established the need or such training, VA explained.

The additional subsistence and dependency allownces provided for Public Law 16 trainees are based n the percentage of disability suffered by the indiidual veteran.

By his refusal to report for re-examination, the eteran makes it impossible for VA to determine his ontinuing eligibility for those additional benefits.

As a result, VA must suspend the additional llowances as well as the disability compensation ntil the veteran submits to the examination and e-establishes his right to the benefits.

Home Town Prescription Service

Pharmaceutical associations in 46 states, the Disrict of Columbia and Hawaii renewed contracts with Veterans Administration to provide "home town" prescription service for eligible veterans during the fiscal year ending June 30, 1949 E. Burns Geiger, chief of VA's pharmacy division, announced.

All states except Nevada and Virginia now are taking part in the drug program.

Under the "home town" service plan, eligible veterans simply take their prescriptions to the nearest drug store to be filled, and VA pays the bill. Fees charged by participating pharmacies are approximately equivalent to average fees for prescriptions charged the general public.

To be eligible for the pharmacy service, a veteran must meet these two requirements:

1. He must be receiving medical treatment for a service connected illness or disability.

2. He must obtain a prescription from a private physician, dentist or osteopathic physician operating under VA's "home town" medical care program or on a fee basis.

Osteopathic physicians may write prescriptions for veterans only in those states where they are permitted to do so by law.

In addition to drugs, certain specified "medical requisites," such as insulin syringes and needles, atomizers, hot water bottles, fountain syringes, ice bags and feeding tubes, are available under the plan. These items may be prescribed only in cases of emergency.

The "home town" pharmacy program, which was started in the Spring of 1946, was designed to reduce reported delays that arose when all prescriptions from fee basis physicians had to be mailed to the nearest VA office and then sent to the veteran by mail.

The project was developed by VA and representatives of the American Pharmaceutical Association and the National Association of Retail Druggists.

Penicillin Not Cure-All for Venereal Disease

Veterans Administration urges all veterans who were treated for syphilis with penicillin during service in the armed forces to undergo periodic check-ups so as to prevent recurrence of the disease.

Between 20 and 30 per cent of the cases treated with penicillin are reported to be "failures," contrary to the popular belief that the drug is a "cure all" for venereal disease, Dr. Bascom Johnson, Jr., assistant chief of dermatology and syphilology in VA's Department of Medicine and Surgery declared.

Veterans who suffered from this disease are urged to report to their private physician or their local health department.

Only veterans with VD adjudged to be service connected are eligible for prompt treatment in VA outpatient clinics or hospitals. Veterans with non service connected VD are eligible for treatment only in hospitals and then only when they say they cannot afford to pay for treatment elsewhere.

Dr. Johnson also urged veterans who contracted gonorrhea during the war and who did not have follow-up blood tests for syphilis once a month for four months following treatment, to report for check-ups and treatment, if necessary.

If gonorrhea is treated with penicillin it sometimes aborts the signs of syphilis contracted at the same time, Dr. Johnson warned.

3,035 Army Hospital Beds Set Aside for Veterans

A total of 3,035 beds in Army hospitals throughout the United States have been allocated for treatment of veterans, Major General Raymond W. Bliss, Surgeon General of the Army, announced recently. The allocations were made at the request of the Veterans Administration.

Beds allotted for veterans may be used partly for treatment of chronic disabilities, with 325 set aside specifically for tuberculosis cases at Fitzsimons General Hospital in Denver. None of the beds allocated will be used for patients who could be treated in domiciles.

The list of hospitals where veterans will be assigned beds: Army and Navy General, Hot Springs, Arkansas, 175 beds allocated; Brooke General, San Antonio, 400; Fitzsimons General, Denver, 700; Letterman General, San Francisco, 175; Madigan General, Tacoma, Washington, 350; McCornack General, Pasadena, 100; Oliver General, Augusta, Georgia, 125; Percy Jones General, Battle Creek, Michigan, 200; Tilton General, Wrightstown, New Jersey, 275; Valley Forge General, Phoenixville, Pennsylvania, 175; Walter Reed General, Washington, D. C., 50; William Beaumont General, El Paso, 150; Fort Benning Station, Columbus, Georgia, 50; Fort Belvoir Station, Accotink, Virginia, 35; Fort Bragg Station, Fayetteville, North Carolina, 50; and Spokane Air Force Base Station, Spokane, Washington, 25.

Compensation on Presumptive Evidence

Veterans of peace time service in the regular military or naval establishment, who served six months or more and who received honorable discharges, are now entitled to certain presumptions of service connection for compensation purposes where tropical diseases become manifest after discharge, Veterans Administration has announced.

These presumptions, heretofore accorded only to war time veterans, result from Public Law 748 of the last Congress. This law provides that a peace time veteran who contracts a tropical disease within one year from discharge, or within the accepted incubation period for the particular disease, will be deemed to have incurred the disease in service, unless there is clear evidence to the contrary.

The Act also writes into law certain presumptions for war time veterans which previously were granted under administrative authority. It further extends the list of chronic and tropical diseases to which such presumptions shall apply.

The list of diseases includes yaws, leprosy, dysentery, filiarisis, leischmaniasis, malaria, schistosomiasis, loiasis, black water fever, onchoceriasis, oroya fever, dracontiasis, pinta and yellow fever.

Home Town Medical Care Contract Renewed

Samuel B. Rentsch, Derby, chairman of the Society's Committee on Veterans' Medical Care, recently announced that the committee has renewed its contract with the Veterans Administration for the period July 1, 1948 to June 30, 1949.

As of July 15, 1,173 Connecticut physicians were enrolled in the Home Town Medical Care Plan for Veterans, with enrollments in the state's eight counties as follows: New Haven County—364; Hartford County—334; Fairfield County—293; Litchfield County—54; Middlesex County—29; Windham County—25; and Tolland County—9.

MILITARY BIOGRAPHIES (*Continued*)

These brief sketches of military experience of members of the Society have been compiled from data taken from questionnaires completed by each medical officer. Biographical material for some officers is lacking because questionnaires were not returned.

LA, WILLIAM E., New Britain; b. 9; Loyola 1937; Army—November 1942 Lt., Captain March 1944; Serv- Terminated March 27, 1946; Duty— lisle Barracks, Pa.; Bn. Surgeon— th Africa-Sicily-England-Normandy- ice (North African-Mediterranean- opean Theatres of Operation); rds—4 Bronze battle stars; Unit tion.

MEROY, WILLIAM H., Poquonock; 915; Maryland 1943; Army—October 944 Lt., Captain July 2, 1946; Service minated December 9, 1946; Duty— nes General Hospital, Vancouver, h.; Letterman General Hospital, San ncisco, Calif.; Award—Presidential t Citation.

'KIN, MICHAEL S., Bridgeport; b.); George Washington 1935; Army— ch 11, 1943 Lt., Captain January 28, 4; Service Terminated February 25, 5; Duty—Ft. Devens, Mass.; North- on General Hospital, Tuscaloosa, ; 129th General Hospital; 164th eral Hospital (European Theatre of rations); Award—Letter of Com- dation.

T, EDWARD A., Waterbury.

STON, THOMAS R., West Hart- ; b. 1899; Yale 1925; Army—Febru- 12, 1944 Major; Lt. Colonel Febru- 20, 1945; Service Terminated August 1947; Duty—Veterans Administra- Hospital, Newington, Conn.; Vet- s Administration, Hartford, Conn.; phy General Hospital, Waltham, s.

GNANO, JOHN V., Manchester; b. 4; Georgetown 1940; Army—Febru- 17, 1944 Captain; Service Terminated 20, 1946; Duty—Veterans Admin- tion Hospital, Newington, Conn.

LEN, RICHARD W., New Britain; 1 in Service).

RNEY, JOHN, New Britain; b. 1910; ill 1939; Navy—April 4, 1943 Lt. .), Lt. June 1944; Service Terminated 27, 1946; Duty—New York, N. Y.; voy duty (Atlantic); Pensacola, Fla.; Seattle, Wash.; Flight Surgeon—USS Tulagi (Asiatic-Pacific Theatre of Operations); Westerly, R. I.; Jacksonville, Fla.

PURPLE, MAYO R., East Hampton; Died January 19, 1945.

QUATRANO, JOSEPH C., Bridgeport; b. 1901; Vermont 1931; Navy—December 14, 1942 Lt. Comdr.; Service Terminated May 10, 1945; Duty—Chelsea, Mass.; Jacksonville, Fla.; Ft. Eustis, Va.

RADEMACHER, EVERETT S., New Haven; b. 1899; Iowa 1923; P.H.S.—(US CG)—July 20, 1942 Surgeon (R), Senior Surgeon (R) March 1945; Service Terminated June 5, 1946; Duty—Manhattan Beach, N. Y.; New London, Conn.

RAFFA, JOSEPH, Glastonbury; b. 1908; Columbia 1934; Navy—November 20, 1943 Lt., Lt. Comdr. December 1, 1945; Service Terminated March 29, 1946; Duty—LST 56 (European Theatre of Operations); AIA 51, USS Sheridan (Asiatic-Pacific Theatre of Operations).

RANKIN, EMMETT C., New Britain.

RAPP, ALBERT G., New London; b. 1903; Cornell 1929; Army—August 1, 1942; Lt., Captain February 1943, Major April 1944; Service Terminated February 26, 1945; Duty—Camp Pickett, Va.; Walter Reed General Hospital, Washington, D. C.; New Orleans Port of Embarkation, La.; Ft. Sam Houston, Tex.; Army X-Ray Course.

RAWLS, E. COTTON, Stamford; b. 1905; Medical College of Virginia 1931; Navy—August 2, 1943 Lt. Comdr., Commander November 1945; Service Terminated March 22, 1946; Duty—Naval Hospital, Brooklyn, N. Y.; Plymouth, England (European Theatre of Operations); Separation Center, New York, N. Y.

RAYMER, JOHN G., Norwich; b. 1901; Harvard 1925; Navy—March 1, 1943 Lt. Comdr., Commander November 1, 1945; Service Terminated March 8, 1946; Duty—Quonset Point, R. I.; USS Starlight (Asiatic-Pacific Theatre of Operations); St. Albans, N. Y.; Awards—2 Letters of Commendation.

REDLICH, FREDRICK C., New Haven; b. 1910; Vienna (Austria) 1935; Army—August 24, 1944 Lt., Captain September 24, 1945; Service Terminated November 16, 1945; Duty—Carlisle Barracks, Pa.; New Orleans, La.; Tuscaloosa, Ala.; Swannanoa, N. C.

REICHENBACH, ALFRED E., Waterbury; b. 1914; Tufts 1938; Army—May 7, 1943 Lt., Captain January 4, 1944; Service Terminated April 11, 1946 (Major); Duty—Continental United States.

REIDY, JOSEPH C., Winsted; b. 1918; George Washington 1943; Army—September 16, 1944 Lt., Captain October 1, 1945; Service Terminated December 25, 1946; Duty—Carlisle Barracks, Pa.; Chickasha, Okla.; Clinton, Ia.; USS Mercy, USAT Fred C. Ainsworth (Asiatic-Pacific Theatre of Operations); Award—Meritorious Service Placque.

REITER, BENJAMIN R., Bridgeport; b. 1908; Harvard 1934; Army—August 25, 1942 Captain, Major October 24, 1943; Service Terminated August 8, 1945; Continental United States; North African-Mediterranean-European Theatres of Operations; Awards—Presidential Unit Citation; Bronze star.

RENTSCH, SAMUEL B., Derby; b. 1893; Michigan 1923; Navy—November 22, 1943 Lt. Comdr.; Service Terminated November 17, 1945; Duty—Portsmouth, N. H.; Seattle, Wash.; US Attack Transport MENIFEE; (World War I (Navy) December 17, 1917 to April 15, 1919).

REYNOLDS, JOSEPH A., Waterbury; b. 1910; Tufts 1936; P.H.S.—December 7, 1943 P.A. Surgeon, Surgeon December 1944; Service Terminated April 17, 1946; Duty—U. S. Marine Hospital, Cleveland, Ohio.

REYNOLDS, WHITMAN M., Greenwich; b. 1905; Columbia 1931; Army—September 17, 1942 Captain, Major De-

cember 21, 1944; Service Terminated January 2, 1946 (Lt. Colonel); Duty—Carlisle Barracks, Pa.; Ft. Lewis, Wash.; Camp Hale, Colo.; Camp Swift, Tex.; Ft. Benning, Ga.; Ft. McPherson, Ga.

RIBNER, HAROLD, Bridgeport; b. 1908; Tufts 1934; Army Air—December 24, 1942 Lt., Captain January 6, 1944, Major June 1, 1946; Service Terminated July 22, 1946; Duty—Lowry Fld., Colo.; Lincoln, Nebr.; Wichita Falls, Tex.

RICCA, RENATO A., Glastonbury.

RICHARDS, WILLIAM R., New Haven (Entered service from New York City); b. 1908; Cornell 1935; Army Air—August 13, 1943 Lt., Captain June 1, 1944; Service Terminated September 1, 1946 (Major); Duty—Carlisle Barracks, Pa., Kearns, Utah; McDill Fld., Fla.; Esler Fld., La.; Greenville, S. C.; Selfridge Fld., Mich.

RIESMAN, JOHN P., Branford (Entered service from Philadelphia, Pa.); b. 1912; Pennsylvania 1938; Navy—May 17, 1943 Lt. (j.g.), Lt. August 1, 1944; Service Terminated May 13, 1946; Duty—Norfolk, Va.; Little Creek, Va.; Amphibious Advanced Bases in England, HMS Capetown-Omaha and Utah Beaches, Invasion of Normandy; Naval Hospital, St. Albans, N. Y.

RINDGE, NORMAN P., Clinton; b. 1908; Yale 1935; Army Air (to Ground Forces August 15, 1944)—October 2, 1942 Lt., Captain July 9, 1943; Service Terminated November 30, 1945; Duty—Continental United States and European Theatre of Operations; Awards—3 Bronze service stars; Bronze Arrowhead; Combat Medical Badge; Presidential Unit Citation; Belgian and Dutch Fourrageres.

ROBB, SAMUEL A., Meriden (Entered strvice from Jamaica, N. Y.); b. 1914; Cornell 1940; Army—July 8, 1944 Lt., Captain July 1945; Service Terminated November 29, 1946; Duty—Carlisle Barracks, Pa.; Ft. Knox, Ky.; Edgewood Arsenal, Md.; 7th and 156th Station Hospitals, Okinawa (Asiatic-Pacific Theatre of Operations).

ROBBINS, ALBERT I., New Haven; b. 1914; Vermont 1939; Army—April 21, 1941 Lt., Captain December 1942; Service Terminated September 1944; Duty—Ft. Devens, Mass.; 52nd Evacuation Hospital (Asiatic-Pacific Theatre of Operations); Fitzsimons General Hospital, Denver, Colo.

ROBBINS, CLARENCE L., New Haven (Removed to Arizona).

ROBERTS, FREDERICK W., New Haven; b. 1900; Johns Hopkins 1924; Navy—October 19, 1942 Lt. Comdr., Commander November 1, 1945; Service Terminated December 8, 1945; Duty—Sub. Base, New London, Conn.; Camp Peary, Va.; St. Albans, N. Y.; Brooklyn, N. Y.; Argentia, Newfoundland; Sampson, N. Y. (Wold War I—April 1918—December 1918).

ROBINSON, WILFRED J., Broad Brook; b. 1893; Long Island College of Medicine 1921; Army—June 18, 1943 Captain, Major April 19, 1946; Service Terminated July 12, 1946; Duty—Atlanta, Ga.; New Orleans, La.; Ft. McClellan, Ala.; Camp Van Dorn, Miss.; School of Tropical Medicine, Washington, D. C.; 120th General Hospital, New Guinea and Luzon, P. I.; USS Augustus Thames; Camp John Hay, Baguio (Asiatic-Pacific Theatre of Operations; Awards—5 battle stars.

ROBISON, ROY C., Stamford; b. 1909; Yale 1936; Army—July 10, 1941 Lt., Captain January 10, 1944; Service Terminated February 7, 1946; Duty—Ft. Ethan Allan, Vt.; Ft. Devens, Mass.; Iceland (European Theatre of Operations); Camp Stoneman, Calif.; 8th General Hospital, New Caledonia; 39th General Hospital, Auckland, N. Z.; 29th General Hospital, New Caledonia (Asiatic-Pacific Theatre of Operations); Oakland, Calif.; HMS Queen Elizabeth (Scotland); Ft. Hamilton, N. Y.

ROCCAPRIORE, BENJAMIN A., Middletown.

ROCH, GEORGE E., Willimantic; b. 1908; Tufts 1934; Navy—June 7, 1943 Lt., Lt. Comdr. October 3, 1945; Service Terminated May 23, 1946; Duty—St. Albans, N. Y.; Sun Valley, Idaho; USS Crescent City, USS LSM(R) 194 (Asiatic-Pacific Theatre of Operations); Chelsea, Mass.

ROGAWSKI, ALEXANDER S., New Haven.

ROGERS, FREDERICK P., West Hartford.

ROGERS, ROBERT P., Greenwich; b. 1900; Harvard 1925; Army Air—August 4, 1942 Major, Lt. Colonel November 1944; Service Terminated October 12, 1945; Duty—Patterson Fld., Ohio; Langley Fld., Va.; Civil Affairs Italian Sch Yale Univ., New Haven, Conn.; Sc of Tropical Medicine, Washington C.; Sicily; U. S. Typhus Commis Naples, Italy; Civil Affairs Fr School, Algeria (North African-M terranean-European Theatre of O tions); Awards—Bronze star; U Typhus Commission Medal; 5 b stars.

ROGOL, LOUIS, Danbury; b. 1908; Island College of Medicine 1933; A —June 13, 1942 Lt., Captain Januar 1943; Service Terminated May 2, (Major); Duty—Continental U States; England; North Africa; I Awards—3 battle stars.

ROMANIELLO, ROCCO J., Elmw b. 1901; Columbia 1927; Navy—Oct 9, 1943, Lt Comdr., Commander No ber 5, 1945; Service Terminated 15, 1946; Duty—Sub. Base, New don, Conn.; Charleston Navy Y Boston, Mass.; Naval Base, San Bi Calif.; Naval Hospital, Adak, Alask

ROOT, JAMES H., JR., Waterbur 1916; Syracuse 1943; Army—Jul 1945 Lt., Captain September 10, Service Terminated April 28, Duty—Carlisle Barracks, Pa.; Ft. L Colo.; O'Reilly General Hospital, Sp field, Mo.; Ft. Benning, Ga.

ROSE, SAMUEL A., Stamford.

ROSEN, THEODORE, Manchester tered service from Walla Walla, W ington); b. 1908; Tufts 1933; Na December 1, 1943 Lt., Lt. Comdr. De ber 1, 1945; Service Terminated Oct 19, 1946; Duty—Farragut, Idaho; man, Okla.; Camp Wallace, Texas; H ton, Texas.

ROSENBAUM, GEORGE J., Hart b. 1908; Tufts 1934; Navy—Januar 1944 Lt., Lt. Comdr. February 1, Service Terminated April 15, 1946; —Camp Peary, Va.; Solomons, Ocean View, Va.; Camp Bradford, Panama City, Fla.; LST Group Me Officer, Dartmouth, England—Lon derry, Northern Ireland (Euro Theatre of Operations); Chelsea,

ROSENBAUM, JACK D., New H (Removed to Massachusetts).

ROSENBERG, HAROLD A, Wate (Entered service from Jackson Hei N. Y.); b. 1906; Yale 1930; Navy— ber 26, 1942 Lt., Lt. Comdr. July 8,

ice Terminated December 27, 1945; y—New York, N. Y.; Staten Island, Y.; Midway Island; Oahu, T. H.; nawa (Asiatic-Pacific Theatre of Op-ions); Awards—2 bronze stars.

SENBERG, SAUL, Bridgeport (En-d service from Brooklyn, N. Y.); b. 2; American University of Beirut ria) 1939; Army—March 24, 1944 Service Terminated May 8, 1946; y—Carlisle Barracks, Pa.; Denver, o.; School of Tropical Medicine, shington, D. C.; Camp Ellis, Ill.

SENTHAL, BENJAMIN B., Milford ntered service from Brooklyn, N. Y.); 1906; New York University 1930; ny—April 20, 1942 Lt., Captain rch 1943; Service Terminated Febru-18, 1946; Duty—Continental United es and Asiatic-Pacific Theatre of erations.

SENTHAL, RICHARD L., Branford ntered service from New York City); 1914; Long Island College of Medi-e 1938; Army—July 11, 1942 Lt., ptain September 9, 1943; Service Ter-nated April 5, 1946; Duty—Carlisle racks, Pa.; Chemical Warfare School, gewood Arsenal, Md.; Ft. George G. ade, Md.; Camp McCoy, Wisc.; Camp kett, Va.; Asiatic-Pacific Theatre of erations; Awards—Bronze star; Asi--Pacific Service Medal w/Bronze owhead.

TH, OSCAR, New Haven; b. 1910; nna (Austria) 1937; Army—May 17, 4 Lt., Captain April 1945; Service rminated August 27, 1946; Duty—lisle Barracks, Pa.; Army and Navy neral Hospital, Hot Springs, Ark.; 1st Evacuation Hospital England-nce - Germany - Austria (European eatre of Operations); Brooke General spital, San Antonio, Tex.

URKE, THOMAS A., Greenwich; b. 07; Columbia 1937; Army—October 1942 Lt., Captain June 1943; Service rminated February 2, 1946; Duty—rmandy, Northern France, Rhineland, ntral Europe (European Theatre of erations); Award—Bronze star.

OY, JOSEPH L., North Grosvenordale; 1909; Tufts 1934; Army Air—January 1941 Captain, Major November 17, 43; Service Termniated February 5, 46; Duty—Camp Edwards, Mass.; hool of Aviation Medicine, Randolph d., Tex.; Washington, D. C.; European Theatre of Operations; Miami Beach, Fla.; Awards—Unit Citation; Pre-Pearl Harbor Ribbon; (Recalled to active duty November, 1946).

ROZEN, ALAN A., New Haven; b. 1911; Yale 1937; Army—August 20, 1942 Lt., Captain February 19, 1944; Service Terminated July 29, 1946; Duty—Camp Edwards, Mass.; European Theatre of Operations.

RUBIN, GEORGE A., New Haven; b. 1905; Edinburgh (Scotland) 1932; Army—October 8, 1942 Captain; Service Terminated November 9, 1945; Duty—Ft. Devens, Mass.; Camp Barkeley, Tex.; Camp Stoneman, Calif.; New Orleans, La.; Charleston, S. C.; European Theatre of Operations; Camp Shanks, N. Y.; Awards—4 battle stars.

RUBIN, ALBERT, Hartford (Entered service from Utica, N. Y.); Geneva (Switzerland) 1929; Army—July 9, 1942 Captain, Major January 1946; Service Terminated April 6, 1946; Duty—Pine Camp, N. Y.; 90th, 236th, 216th General Hospitals, 51st Field Hospital—England-France-Germany (European Theatre of Operations); Awards—2 battle stars.

RUBIN, DAVID, South Norwalk.

RUBY, ROBERT J., Waterbury.

RUDNICK, CHARLES J., Brdigeport.

RUP, EDMUND C., West Hartford.

RYAN, FRANCIS J., Hartford; b. 1909; Tufts 1935; Army—February 23, 1944 Major, Lt. Colonel May 6, 1946; Service Terminated June 18, 1946; Duty—Continental United States.

RYAN, V. GERARD, Portland; b. 1910; Yale 1934; USPHS—August 13, 1943 P.A. Surgeon (R); Surgeon (R) October 1944; Inactive Duty—October 27, 1945; Duty—Chief Medical Officer, Merchant Marine Rest Center, Pass Christian, Miss.; Regional Gulf Supervisor, Recruitment & Manning Organization, WSA; Chief Medical Officer, Merchant Marine Rest Center, Gladstone, N. J.; Medical Executive Officer, Recruitment & Manning Organization and United Seaman's Service (WSA).

RYLEY, ROGER N., Mystic; b. 1907; Yale 1939; Navy—September 9, 1942 Lt. (j.g.), Lt. November 1943, Lt. Comdr. September 1945; Service Terminated November 1945; Duty—Newport, R. I., L.C.I. (1) Flotilla 1, Squadron 2—L.C.I. (1) Flotilla 2, Group 4—L.S.T. #492; Sub. Base, New London, Conn.

SABIA, DANIEL J., Stamford (Entered service from Los Angeles, Calif.); b. 1909; Marquette 1936; Army—February 26, 1944 Captain; Service Terminated July 9, 1946; Duty—Veterans Administration, Los Angeles, Calif.

SABLOFF, JACK, Manchester; b. 1908; Long Island College of Medicine 1934; Army—August 13, 1942 Lt., Captain May 15, 1943; Service Terminated February 17, 1946; Duty—Carlisle Barracks, Pa.; Camp Barkeley, Tex.; Louisiana—CAMA Desert Maneuvers; European Theatre of Operations; Awards—Silver star; Purple Heart; Medical Combat Badge; European Theatre Ribbon w/ arrowhead and 3 bronze battle stars.

SACHS, KURT, New Haven; b. 1910; Vienna (Austria) 1935; Army—(Non-commissioned November 24, 1944—July 9, 1945) July 10, 1945 Lt., Captain January 29, 1947; Service Terminated March 24, 1947; Duty—Camp Barkeley, Tex.; Camp Crowder, Mo.; Ft. Leonard Wood, Mo.; Carlisle Barracks, Pa.; Ft. Riley, Kan.; 153rd Station Hospital—4th General Hospital—1315th Engr. Constr. Bn.—13th Station Hospital—War Crimes Trials (Asiatic-Pacific Theatre of Operations); Award—Letter of Commendation.

SADUSK, JOSEPH F., JR., New Haven; b. 1909; Johns Hopkins 1935; Army—March 2, 1942 Captain, Major October 4, 1942, Lt. Colonel May 8, 1943, Colonel December 19, 1944; Service Terminated July 31, 1946; Duty—Army Medical School, Washington, D. C.; U. S. A. Typhus Commission, War Department, Washington, D. C.; Hawaiian Department; Australia; New Guinea; Supreme Headquarters, AEF; GHQ, American Forces Pacific Ocean (Philippines, Japan, Korea); Awards—Legion of Merit w/1 oak leaf cluster; USA Typhus Commission Medal; Asiatic-Pacific Theatre Ribbon w/2 battle stars; European-North African-Middle Eastern Theatre Ribbon w/2 battle stars; (Removed to Orange, N. J.).

SALTZMAN, JACOB A., Waterbury; b. 1905; New York Medical College 1933; Army—June 10, 1942 Lt., Captain 1943; Service Terminated May 23, 1946; Duty—Ft. Devens, Mass.; North African-Mediterranean Theatre of Operations

SAMPONARO, NICHOLAS, Torrington; b. 1903; Johns Hopkins 1929; Navy —December 13, 1943 Lt. Comdr.; Commander December 1945; Service Terminated July 2, 1946; Duty—U. S. Naval Hospital, Quantico, Va.

SAMSON, DANIEL P., Thomaston; b. 1917; Columbia 1943; Army—October 7, 1944 Lt., Captain 1945; Service Terminated October 1946; Duty—Ft. Lewis, Wash.; 3rd General Hospital—198th General Hospital—50th Field Hospital—Post Surgeon-Prisoner of War Camp (European Theatre of Operations); Award—1 battle star.

SANDERSON, ROY V., Winsted; b. 1892; Vermont 1920; Navy—July 24, 1944 Lt. Comdr.; Service Terminated April 23, 1946; Duty—Portsmouth, N. H.; Fleet Hospital 103, Guam, M. I. (Asiatic-Pacific Theatre of Operations); St. Albans, N. Y.

SAPOSNICK, JACOB J., West Haven; b. 1907; Howard 1933; Army—September 25, 1942 Lt., Captain June 1944; Service Terminated February 16, 1946 (Major); Duty—Camp Kilmer, N. J.; Army Hospital Ship Aleda E. Lutz, Pearl Harbor, T. H. (Asiatic-Pacific Theatre of Operations).

SAUNDERS, ALLEN I., New Haven (Removed).

SAUNDERS, GEORGE R., Old Saybrook (Entered service from Maplewood, N. J.); b. 1915; Cornell 1941; Army—July 15, 1942 Lt., Captain August 22, 1943, Major January 16, 1946; Service Terminated February 24, 1946; Duty—Africa —2nd Auxiliary Surgical Group; USA Hospital Ship St. Olaf (European Theatre of Operations—Asiatic-Pacific Theatre of Operations).

SAYERS, DANIEL O., Waterbury; b. 1909; Tufts 1935; Army Air—September 22, 1943 Lt., Captain November 11, 1944; Service Terminated July 19, 1946; Duty —Robins Fld., Ga.; Nashville, Tenn.; Louisville, Ky.; School of Aviation Psychiatry, Ft. Logan, Colorado; Santa Ana, Calif.; Ft. George Wright, Spokane, Wash.; Crossroads Project.

SAYERS, JOHN J., Hartford; b. 1908; Tufts 1935; Army—May 7, 1943 Lt., Captain April 1, 1944; Service Terminated March 4, 1946; Duty—Carlisle Barracks, Pa.; Camp Grant, Ill.; European Theatre of Operations.

SCANLON, JOHN J., South Norwalk; b. 1910; Georgetown 1935; Army—April 1, 1941 Lt., Captain November 1941, Major April 1943; Service Terminated October 13, 1945 (Lt. Colonel); Duty—Camp Edwards, Mass.; Camp Atterbury, Ind.; Camp Forrest, Tenn.; Carolina Maneuvers; Tennessee Maneuvtrs; European Theatre of Operations; Awards—5 battle stars; Bronze star; Unit Citation.

SCHAEFER, JACOB, East Hartford.

SCHATTEN, SIEGFRIED S., New Britain.

SCHILANDER, CARL A., Somers; b. 1889; Tufts 1909; Army—July 10, 1941 Captain, Major 1941, Lt. Colonel 1944, Colonel 1945; Service Terminated March 14, 1946; Duty—198th C. A. (A.A.) Asiatic-Pacific Theatre of Operations; Ft. Banks, Mass.; 194th—1st General Hospital European Theatre of Operations; Awards—French Legion of Honor; Croix de Guerre; Purple Heart; Combat Surgeon's Awards; Presidential Unit Citation.

SCHMIDT, NORMAN L., Stamford; b. 1897; Vanderbilt 1927; Navy—July 11, 1943 Lt. Comdr.; Commander November 5, 1945; Service Terminated February 5, 1946; Duty—Newport, R. I.; Eastern Sea Frontier, Staten Island, N. Y.; Convoy Duty (Caribbean); USS Adirondack (Atlantic).

SCHNAP, ISIDORE, East Hartford (Entered service from Kings Park, N. Y.); b. 1906; Long Island College of Medicine 1929; Army—May 17, 1942 Captain, Major January 1943, Lt. Colonel April 2, 1946; Service Terminated July 15, 1946; Duty—Camp Gordon, Ga.; Camp Shelby, Miss.; Award—Certificate of Commendation.

SCHNEIDER, WILLIAM, Rockville; b. 1905; George Washington 1930; Army—August 1, 1942 Captain, Major November 8, 1945; Service Terminated February 18, 1946; Duty—Hawaii; Guadalcanal, New Britian; Luzon, P. I. (Asiatic-Pacific Theatre of Operations); Awards —Bronze Arrowhead; 2 battle stars.

SCHOPICK, LOUIS E., Bridgeport (Entered service from Bronx, N. Y.); b. 1907; Zurich (Switzerland) 1935; Army —September 7, 1942 Lt., Captain April 1943; Service Terminated March 3, 1946; Duty—School of Tropical Medicine, Washington, D. C.; Ft. Jackson, S. G., —Louisiana and Desert maneuvers; Guadalcanal; Okinawa (Asiatic-Pa Theatre of Operations); Award—L of Commendation.

SCHWARTZ, HERBERT N., Hart (Entered service from Tulsa, Okla.) 1912; Medical College of Virginia 1 Army Air—June 8, 1942 Lt., Cap October 1943; Service Terminated tember 20, 1946; Duty—Will Ro Fld., Okla.; 99th General Hos (European Theatre of Operations).

SCOTT, J. CLIFFORD, Essex; b. 1 Pennsylvania 1933; Navy—Decembe 1942 Lt., Lt. Comdr. October 1, 1 Service Terminated April 2, 1946; D —Bainbridge, Md.; School of N Aviation Medicine, Pensacola, Hampton Roads, Va.; Marine Air Wing, Cherry Point, N. C.; 613th Ma Bombing Squadron—Marine Air Group 94 (Asiatic-Pacific Theatre Operations); Quonset Point, R. Awards—1 battle star; Presidential U Citation.

SCOVILLE, DOROTHEA H., New I don; b. 1893; Cincinnati 1919; P.H. January 18, 1944 Surgeon; Service minated October 15, 1945; Duty— ing County Health Officer—Cla County, Oregon.

SCOVILLE, WILLIAM B., Hartford 1906; Pennsylvania 1932; Army— cember 20, 1942 Captain, Major May 1945; Service Terminated November 1945; Duty—McCaw General Hospi Cushing General Hospital, Framingh Mass.

SCULLY, MICHAEL R., Bridgeport (tered service from Brooklyn, N. Y.) 1915; Columbia 1941; Navy—Octo 12, 1942 Lt. (j.g.), Lt. January 19 Lt. Comdr. January 1946; Service Ter nated August 18, 1946; Duty—U Guest (Asiatic-Pacific and Europ Theatres of Operations); Naval Amm nition Depot, Earle, N. J.; Award 4 battle stars.

SEIBERT, ALFRED F., Hartford; 1901; Yale 1927; Army—January 1943 Captain; Service Terminated Ma 12, 1946 (Major); Duty—Carlisle B racks, Pa.; Camp Shelby, Miss.; 15 Station Hospital — New Caledonia Guadalcanal - Green Island — Bouga ville; 47th General Hospital, Luzon, P (Asiatic-Pacific Theatre of Operation

SELLEW, ROBERT C., JR., No Canaan; b. 1907; Long Island College

dicine 1936; Army—April 8, 1944 , Captain February 1, 1945; Service rminated June 10, 1946; Duty—Car- e Barracks, Pa.; Hot Springs, Ark.; mp Rucker, Ala.; Camp Cook, Calif.; gland, France, Belgium, Luxemburg, rmany, Austria; Awards—European eatre of Operation Ribbon w/3 battle rs; Combat Medical Badge.

RRELL, HOWARD P., Greenwich; b. 05; Cornell 1932; Army—November 6, 42 Captain, Major March 21, 1944; vice Terminated September 29, 1945; ty—European Theatre of Operations; vards—Silver star; Bronze star.

RENA, FRANK A,. South Norwalk.

RENA, JOHN M., South Norwalk.

TTE, ALFRED J., Stamford; b. 1900; orge Washington 1927; Navy—Janu- 11, 1943 Lt. Comdr. Commander vember 1, 1945; Service Terminated rch 7, 1946; Duty—Sub. Base, New ndon, Conn.; Armed Forces Induction nter, New York, N. Y.; USS Nestor; S Hector; Award—Letter of Com- ndation.

IAFFER, IRVIN G., New Haven (En- ed service from Reading, Pa.); b. 14; Jefferson 1940; Army—July 14, 43 Lt., Captain February 22, 1944; rvice Terminated July 14, 1946 Iajor); Duty—New Orleans, La.; 168th neral Hospital—277th General Hos- tal (European Theatre of Operations); oodrow Wilson General Hospital, unton, Va.; Tilton General Hospital, . Dix, N. J.; Award—Certificate of erit.

HAFFER, THOMAS E., New Haven Removed to Ohio).

HEA, CORNELIUS J., Bridgeport.

HEIMAN, MILTON, Bridgeport; b. 15; Michigan 1939; Army—June 12, 42 Lt., Captain September 1943, Major ecember 1945; Service Terminated pril 17, 1946; Duty—Portland, Me.; ropean Theatre of Operations.

HEIMAN, SAMUEL C., Bridgeport; b. 17; Michigan 1940; Army—September , 1942 Lt., Captain March 18, 1944; rvice Terminated March 15, 1946; uty—Ft. Preble, Maine; East Coast rocessing Centre, Camp Edwards, Mass.

HENKER, BENJAMIN M., Middle- wn; b. 1913; New York Medical Col- ge 1938; Army—July 12, 1941 Lt., Captain February 1942; Service Terminated August 3, 1945; Duty—European Theatre of Operations.

SHERMAN, BENJAMIN, Bridgeport (Entered service from Morristown, N. J.); b. 1904; George Washington 1929; Army—October 20, 1943 Captain, Major May 5, 1946; Service Terminated June 28, 1946; Duty—Carlisle Barracks, Pa.; Ft. Benning, Ga.; 135th General Hosptial—114th General Hospital—241st General Hospital (European-African-Middle Eastern Theatre of Operations).

SHERMAN, IRVING J., Bridgeport (Entered service from Baltimore, Md.); b. 1916; Johns Hopkins 1940; Army—June 29, 1943 Lt., Captain September 1944, Major December 1946; Service Terminated May 27, 1946; Duty—Memphis, Tenn.; 168th Station Hospital—108th Evacuation Hospital (European Theatre of Operations); Staten Island, N. Y.; Awards—3 battle stars; Meritorious Service Plaque.

SHERMAN, SAUL H., Stamford; b. 1908; Columbia 1934; Army—April 24, 1942 Lt., Captain March 1, 1944; Service Terminated January 7, 1946 (Major); Duty—Ft. Devens, Mass.; 136th Station Hospital (European Theatre of Operations); School of Chemical Warfare.

SHERWOOD, PAUL M., Hartford; b. 1915; Boston University 1942; Army Air —August 12, 1943 Lt., Captain May 1944, Major June 1946; Service Terminated September 20, 1946; Duty—School of Applied Tactics, Air Surgeons' Course, Orlando, Fla.; Station Hospital, Boca Raton, Fla.

SHULL, JOHN C., Hartford; b. 1911; Harvard 1936; Navy—August 1, 1943 Lt. (j.g.); Service Terminated September 1, 1944; Duty—Sampson, N. Y.; USS Glennon (Atlantic).

SHULMAN, DAVID N., Hartford.

SHUMACKER, HARRIS B., JR., New Haven (Entered service from Baltimore, Md.); b. 1908; Johns Hopkins 1932; Army—April 20, 1942 Captain, Major October 20, 1943, Lt. Colonel September 3, 1945; Service Terminated May 7, 1946; Duty—118th General Hospital—47th Station Hospital (Asiatic-Pacific Theatre of Operations); Percy Jones General Hospital, Battle Creek, Mich.; Mayo General Hospital, Rochester, Minn.; Awards—Letter of Commendation; 1 battle star.

SHURE, A. LEWIS, New Haven; b. 1902; Tufts 1927; Army—August 17, 1942 Captain; Service Terminated April 16, 1946 (Major); Duty—Northern Ireland, Africa, Italy (European-African-Mediterranean Theatres of Operation); Ft. Knox, Ky.; Awards—5 battle stars, Army Commendation Ribbon.

SIEGE, A. G., Bridgeport.

SIGEL, HARRY, New Haven (Entered service from Cincinnati, Ohio); b. 1910; Tufts 1934; Army—October 7, 1944 Lt., Captain July 1945; Service Terminated August 18, 1946; Duty—Ft. Knox, Ky.; 318th General Hospital—364th Station Hospital—13th General Hospital, Oahu, Okinawa, Kyoto and Osaka, Japan (Asiatic-Pacific Theatre of Operations).

SILLS, THEODORE, Newington.

SILVER, GERSHON B., Hartford; b. 1911; Tufts 1937; Army Air—November 11, 1940 Lt., Captain June 1942, Major June 1945; Service Terminated September 12, 1945; Duty—Ft. Wright, N. Y.; Ft. Devens, Mass.; Bradley Fld., Conn.; School of Aviation Medicine, Randolph Fld., Tex.; Flight Surgeon—European Theatre of Operations; Awards—Pre-Pearl Harbor Ribbon; 2 Presidential Unit Citations; 10 battle stars.

SIMON, BENJAMIN, Middletown; b. 1903; Washington 1931; Army—April 19, 1942 Captain, Major February 14, 1944, Lt. Colonel August 31, 1945; Service Terminated June 27, 1946; Duty—General Dispensary USA, New York, N. Y.; Mason General Hospital, Brentwood, N. Y.; Awards—Meritorious Service Unit Plaque; Legion of Merit; Army Commendation.

SIMONDS, JOHN R., Washington Depot (Entered service from Attleboro, Mass.); b. 1913; Vermont 1938; Army—February 24, 1941 Lt., Captain August 13, 1942; Service Terminated January 24, 1946; Duty—Carlisle Barracks, Pa.; Camp Blanding, Fla.; Bora Bora—Efate, New Hebrides — Guadalcanal-Treasury Islands—Bougainville-Luzon, P. I. (Asiatic-Pacific Theatre of Operations); Award—Letter of Commendation.

SIMSES, JOHN P., Bridgeport; b. 1913; Tufts 1937; Army—September 15, 1942 Lt., Captain June 1943; Service Terminated October 13, 1945; Duty—England-France-Germany (European Theatre of Operations).

SINCLAIR, SYDNEY E., New Haven (Entered service from San Francisco, Calif.); b. 1910; Pennsylvania 1936; Navy—October 7, 1942 Lt. (j.g.), Lt. January 1, 1944, Lt. Comdr. January 1, 1946; Service Terminated February 18, 1946; Duty—Chelsea, Mass.; USS Eaton; Fleet Hospital #105, New Caledonia (Asiatic-Pacific Theatre of Operations); School of Epidemiology, Bethesda, Md.; Quoddy Village, Me.; (Removed to Williamsport, Pa.).

SIVAK, GEORGE C., Ansonia (Entered service from Brooklyn, N. Y.); b. 1917; Cincinnati 1943; Army Air—October 7, 1944 Lt.; Service Terminated December 13, 1946 (Captain); Duty—Carlisle Barracks, Pa.; Maxwell Fld., Ala.; Miami, Fla.; European Theatre of Operations.

SKLAVER, JOSEPH. Waterbury; b. 1911; Michigan 1937; Army—June 15, 1941 Lt., Captain January 1, 1942; Service Terminated October 5, 1945; Duty—Ft. Adams Station Hospital; 7th Station Hospital—England-Oran-Leghorn, Italy (European-African-Mediterranean Theatres of Operation); Awards—2 battle stars; Meritorious Unit Service Plaque.

SLATER, DANIEL, Hamden.

SLATER, MORRIS, Hamden.

SLOSSBERG, DAVID S., Hartford; b. 1907; Tufts 1934; Navy—May 28, 1944 Lt.; Service Terminated May 3, 1946; Duty—Portsmouth, N. H.; Camp Le-Jeune, N. C.; Sixth Marine Division—First Marine Division (Asiatic-Pacific Theatre of Operations); Award—Letter of Commendation.

SMITH, EDWARD R., Meriden; b. 1915; Yale 1940; Navy—August 7, 1944 Lt. (j.g.); Service Terminated December 12, 1945; Duty—Sampson, N. Y.; Bath, Me.; USS Tolman; Portsmouth, Va.; Lido Beach, N. Y.; San Bruno, Calif.; U. S. Naval Hosp., Oakland, Calif.; U.S. N.P.S.C.—Lido Beach, N. Y.

SMITH, FREDERICK F., New Haven; b. 1902; Howard 1930; Army—July 30, 1943 Captain; Service Terminated March 28, 1946 (Major); Duty—Mediterranean and European Theatres of Operation.

SMITH, JAMES T., New Haven; b. 1913; Navy—July 14, 1942 Lt. (j.g.), Lt. US NR April 3, 1943, Lt. USN March 1944, Lt. Comdr. USN October 3, 1946; Service Terminated June 8, 1947; Duty—Naval Hospital, Brooklyn, N. Y.; 26th C. B. Bn., USN Mobile Hosp. #4, USS Tryon (Asiatic-Pacific Theatre of Operations); Naval Hospital, Philadelphia, Pa.; Solomons, Md.; Camp Lejeune, N. C.

SMITH, JASPER A., Waterbury.

SMITH, STEPHEN M., Westport; b. 1898; Tufts 1920; Navy—April 20, 1942 Lt. Comdr., Commander November 1943, Captain November 1945; Service Terminated July 1946; Duty—Boston, Mass.; Bethesda, Md.; Portsmouth, Va.; Palm Beach, Fla.; Jacksonville, Fla.; Award—Letter of Commendation.

SMITH, WILLIAM B., Hartford; b. 1893; Pennsylvania 1922; Army—September 23, 1940 Major, Lt. Colonel February 1941; Service Terminated October 9, 1945; Duty—Chief Medical Officer, Connecticut Selective Service System.

SMITH, WILSON F., Hartford; b. 1908; Cornell 1934; Army—June 20, 1942 Captain, Major August 18, 1943, Lt. Colonel March 15, 1946; Service Terminated May 3, 1946; Duty—New Orleans, La.; Charleston, S. C.; Ft. Lewis, Wash.; Atlanta, Ga.

SNEIDMAN, GEORGE I., Hartford; b. 1899; Medical College of Virginia 1936; Army—May 15, 1941 Captain, Major March 30, 1942, Lt. Colonel October 31, 1942, Colonel April 13, 1945; Service Terminated November 20, 1945; Duty—Ft. Devens, Mass.; Carlisle Barracks, Pa.; Ft. Jackson, S. C.; Desert Training Center, Arizona; Camp Pickett, Va.; Hawaii, Leyte (Asiatic-Pacific Theatre of Operations); Awards—2 battle stars.

SNURKOWSKI, CHARLES V., New Haven; b. 1896; Georgetown 1925; Army—February 20, 1941 Major, Lt. Col. August 3, 1943; Duty—Camp Blanding, Florida; Camp Shelby, Mississippi; Fort Ord., California; South Pacific and West Pacific Theatres; Wakeman General Hospital, Indiana; Veterans Administration, Connecticut; Oliver General Hospital, Georgia; Station Hospital, Fort Benning, Georgia; Surgeon General's Office, Washington, D. C.; Still in Service; Awards—Navy and Marine Corps Medal of Valor.

SOIFER, IRVIN T., Hartford.

SOLLOSY, ALEXANDER, Bridgeport; b. 1904; Tufts 1927; Army—October 22, 1942 Captain; Service Terminated December 19, 1945; Duty—64th Station Hospital—Sidi-bel-Abbes, North Africa—43rd General Hospital—Africa-Italy-France—11th Evacuation Hospital—vasion of Southern France (North A can-Mediterranean Theatres of Op tions).

SOLOMKIN, MARK, Hartford; b. 1 St. Louis 1942; Army—August 11, 1 Lt., Captain June 19, 1944; Service minated December 21, 1945; Du Camp Wheeler, Ga.; 36th Station H pital (European Theatre of Operatio

SOLOMON, CHARLES I., Meriden 1902; Yale 1925; Navy—January 4, 1 Lt. Comdr., Commander December 1 Service Terminated April 19, 1946; D —Newport, R. I.; Ft. Bragg, N. C.; H Hospital #9, Oran (North Afr Theatre of Operations); St. Alb N. Y.

SPERANDEO, ANTHONY, N Haven; b. 1900; Yale 1925; Army—1 21, 1942 Captain; Service Termina September 1944; Duty—Camp Edwa Mass.; Scotland-England-North Af (European and North African Thea of Operations).

SPIEGEL, CHARLES M., New Ha b. 1910; Hahnemann 1936; Army—O ber 6, 1942 Lt., Captain October 1943; Service Terminated February 1946; Duty—Hawaii, Saipan, M. I.; N Hebrides; New Caledonia; Okina Korea; Japan (Asiatic-Pacific Theatre Operations).

SPINNER, SAMUEL, New Haven; 1911; Tufts 1935; Army Air—Novem 12, 1942 Lt., Captain September 1943, Major June 28, 1946; Service T minated September 28, 1946; Dut Miami Beach, Fla.; Columbia, S. C.; C lisle Barracks, Pa.; Congaree, S. C., D Fld., Fla.; Barksdale Fld., La.; Deride La.; Stuttgart, Ark.; Memphis, Te Rapid City, S. D.

SPONZO, JAMES J., Hartford; b. 19 Tufts 1938; Navy—March 27, 1944 (j.g.), Lt. October 1, 1945; Service T minated November 27, 1945; Dut Navy Yard, N. Y.; USS Nields; V Units—Trinity College, Hartford a Wesleyan Univ., Middletown, Co Springfield, Mass.; Award—Europ Theatre of Operations Ribbon w/1 ba star.

SQUILLANTE, ORLANDO J., Ro ville.

STANDISH, WELLES A., Hartford; 1899; Yale 1925; Navy—February

); Lt. Comdr.; Commander Novem- 1945; Service Terminated April 4, 9; Duty—Annapolis, Md.; Norfolk, Lion 6, Shoemaker, Calif.—Guam, I. (Asiatic-Pacific Theatre of Opera- s); St. Albans, N. Y.

NESLOW, JOHN S., Waterbury; b. 3; Cornell 1926; Navy—July 27, 1944 Comdr.; Service Terminated June 18, 6; Duty—Bethesda, Md.; Shoemaker, f.

NKARD, WILLIAM F., Stamford; 911; Jefferson 1938; Army (October 1940—October 3, 1941) October 1, 2 Lt., Captain February 1, 1944; Serv- Terminated December 5, 1945; Duty hina-Burma-India Theatre of Opera- is; Awards—2 Unit Citations.

ARRETT, JAY E., Stamford; b. 1904; ts 1930; Army Air—July 17, 1942 tain, Major November 22, 1943; Serv- Terminated March 9, 1946; Duty— erson Barracks, Mo.; Kearns, Utah.

EEGE, THEODORE W., Hartford ntered service from New York City); 1911; Yale 1938; Navy (MC) Febru- 16, 1942 Lt. (j.g.), Lt. October 1, 42, Lt. Comdr. December 16, 1944; vice Terminated March 1, 1946; Duty Philadelphia, Pa.; USS Delta; Albany, Y.; USS Bunker Hill; USS J. C. But- , USN Hospital, Dublin, Ga.; Awards battle stars; 2 Presidential Unit Cita- ns.

EIN, JULIUS D., Milford; b. 1920; lumbia 1944; Army—April 16, 1946 ; Service Terminated December 24, 47; Duty—Kennedy General Hospital, mphis, Tenn.; Medical Field Service hool, Ft. Sam Houston, Tex.; Ft. Ham- on, N. Y.

EPHENSON, CHARLES W., Hart- rd; b. 1897; Harvard 1922; U. S. Civil rvice Commission—January 20, 1944; rvice Terminated Novembr 2, 1945; uty—Kennedy General Hospital, Mem- is, Tenn.

ERRETT, RAYMOND A., Southport Entered service from U. S. Public ealth Service, Terre Haute, Indiana— ly 1941—August 1942); b. 1905; Cor- ll 1939; Army Air—November 12, 42 Captain, Major November 1945; rvice Terminated February 12, 1946; uty—Miami Beach, Fla.; Drew Fld., la.; Hunter Fld., Ga.; Asiatic-Pacific heatre of Operations.

STETSON, CHARLES G., Milford; b. 1909; Cornell 1935; Army—February 21, 1941 Lt., Captain January 1942; Retired November 1943; Duty—Pine Camp, N. Y.; Walter Reed General Hospital, Washington, D. C.; Fitzsimmons General Hospital, Denver, Colo.

STETSON, HAROLD P., Southington; b. 1914; Boston University 1941; Army—July 1, 1942 Lt., Captain February 5, 1943; Service Terminated February 14, 1946; Duty—Carlisle Barracks, Pa.; Camp Robinson, Ark.; 561st F.A. Bn. (European Theatre of Operations); Awards—Bronze star; European Theatre Ribbon w/5 battle stars.

STEVENS, MARVIN A., New Haven (Removed to New York City).

STEVENSON, STUART S., Fairfield; b. 1914; Yale 1939; P.H.S.—July 1943 Asst. Surgeon; Service Terminated December 8, 1945; Duty—Harvard School of Public Health, Boston, Mass.; Florida, Egypt; (Removed to Boston, Mass.).

STEVENSON, WILLIAM R., Bristol.

STEWART, LESTER Q., West Hartford; b. 1902; Yale 1933; Army—December 7, 1942 Captain; Service Terminated March 12, 1946 (Major); Duty—Carlisle Barracks, Pa.; Camp Benning, Ga.; Camp Mackall, N. C.; Camp Forrest, Tenn.; 82nd Airborne Division (European Theatre of Operations); Awards—3 battle stars; Bronze star; Bronze Arrowhead.

STRAYER, LUTHER M., Bridgeport; b. 1905; Harvard 1930; Army—July 15, 1942 Captain, Major November 5, 1945; Service Terminated January 20, 1946; Duty—39th General Hospital—Camp Edwards, Mass., and Auckland, N. Z.; New Hebrides; Saipan, M. I. (Aiastic-Pacific Theatre of Operations).

STREET, JOHN M., New Milford; b. 1915; Duke 1942; Army—May 29, 1943 Lt., Captain August 1944; Service Terminated February 26, 1946; Duty—Ft. Hamilton, N. Y.; 80th Inf. Div.—545th F.A. Bn.—102nd Inf. Div. (European Theatre of Operations); Awards—Meritorious Unit Plaque; Bronze star.

STRICKLAND, HAROLD, Meriden; b. 1897; McGill 1930; Army—November 26, 1942 Captain; Service Terminated January 19, 1946; Duty—Camp Robinson, Ark.; Camp Swift, Tex.; New Guinea-Dutch East Indies (Asiatic-Pacific Theatre of Operations); Ft. Ord, Calif.

STYGAR, JOSEPH S., Derby.

SULLIVAN, ARTHUR B., West Hartford; b. 1911; Yale 1938; Army—February 24, 1941 Lt., Captain September 30, 1942; Service Terminated February 8, 1946; Duty—Continental United States and European Theatre of Operations.

SULLIVAN, ARTHUR F., Waterbury (Entered service from Fall River, Mass.); b. 1917; Jefferson 1942; Army—August 13, 1943 Lt., Captain August 1, 1944; Service Terminated April 28, 1945; Duty —Continental United States.

SUNDQUIST, ALFRED B., Manchester; b. 1907; Tufts 1933; Army—September 6, 1942 Lt., Captain June 4, 1943, Major May 9, 1944; Service Terminated December 16, 1945 (Lt. Colonel); Duty—Macon, Ga.; 10th Mountain Division, Camp Holt, Colo.; European Theatre of Operations; Awards — Glider Badge; European Theatre of Operations Ribbon w/5 battle stars and Bronze Arrowhead.

SUTCH, G. CHARLES, Middletown (Entered service from Howard, R. I.); b. 1913; Minnesota 1941; Army—January 2, 1942 Lt., Captain October 23, 1942; Service Terminated March 1946; Duty—Ft. Devens, Mass.; Camp Edwards, Mass.; Holabird, Md.; Royal Military School of Neuropsychiatry, Birmingham, England; Exeter, England; Oxford, England; Lydney, England; Normandy; Central Germany (European Theatre of Operations); Awards—5 battle stars.

SUTHERLAND, FRANCIS A., Torrington; b. 1902; Harvard 1926; Army—July 15, 1942 Major, Lt. Colonel November 5, 1945; Service Terminated January 29, 1946; Duty—39th General Hospital—148th General Hospital (Asiatic-Pacific Theatre of Operations); Awards—2 Letters of Commendation.

SWARTS, WILLIAM B., Greenwich; b. 1908; Pennsylvania 1934; Army—September 23, 1942 Captain, Major December 1944; Service Terminated February 14, 1946; Duty—Camp Butner, N. C.; Caribbean Defense Command; Camp Robinson, Ark.

SWIFT, WILLIAM E., JR., New Haven; b. 1914; Columbia 1940; Army Air—April 21, 1942 Lt., Captain January 21, 1943; Service Terminated May 6, 1946; Duty—Charlotte, N. C.; School of Avia-

tion Medicine, Randolph Fld., Tex.; Manchester, N. H.; Morocco-Algeria-Tunisia-Italy (Mediterranean Theatre of Operations); Awards — 2 Presidential Unit Citations; 10 battle stars.

SWIRSKY, MORGAN Y., New Haven; b. 1913; New York Medical College 1939; Army—July 8, 1944 Lt., Captain June 1945; Service Terminated October 1, 1946; Duty—Ft. Knox, Ky.; 62nd Fld. Hospital — 220th General Hospital — 302nd Station Hospital—317th Station Hospital (European Theatre of Operations); Awards—1 battle star; Army Commendation Ribbon.

SZLEMKO, EMILE A., Groton; b. 1911; Geneva (Switzerland) 1937; Army—January 1, 1943 Lt., Captain November 29, 1943; Service Terminated January 11, 1946; Duty—Carlisle Barracks, Pa.; Camp Bowie, Tex.; European Theatre of Operations; Awards—5 battle stars; Unit Citation.

TAFFEL, MAX, New Haven; b. 1909; Yale 1931; Army—June 5, 1942 Captain, Major July 14, 1944; Service Terminated February 10, 1946; Duty—Asiatic-Pacific Theatre of Operations; Surgeon General's Office, Washington, D. C.; Award—Bronze star.

TAIT, ARTHUR A., West Hartford.

TATE, WILLIAM J., Deep River; b. 1903; Yale 1929; Army—July 1, 1942 Captain; Service Terminated December 23, 1945; Duty—Lovell General Hospital, Ft. Devens, Mass.; 18th Field Hospital, Camp Bowie, Texas; Persian Gulf Command; China-Burma-India Theatre of Operations; Moore General Hospital, Swannanoa, N. C.

TAYLOR, ANDREW, Hartford; b. 1902; Rush 1929; Navy—January 11, 1943 Lt. Comdr., Commander November 15, 1945; Service Terminated July 1, 1946 (Retired); Duty—Brooklyn, N. Y.; Fleet Hospital #109 — Australia; N.A.B.U. #4 Philippine Islands (Asiatic-Pacific Theatre of Operations); Sampson, N. Y.

TAYLOR, HOYT C., Meriden; b. 1911; Cornell 1938; Navy—August 14, 1943 Lt. (j.g.), Lt. December 1, 1944; Service Terminated December 23, 1945; Duty—Continental United States and European Theatre of Operations.

TAYLOR, ROBERT M., East Haven; b. 1897; George Washington 1922; Navy—May 10, 1945 Lt. Comdr., Service Terminated March 30, 1946; Duty—Chelsea, Mass.; Samar, P. I.; USS Ticonderoga (Asiatic-Pacific Theatre of Operations).

TEIGER, PAUL, Waterbury (Entered service from New York City); b. 1912; Columbia 1939; Army—July 31, 1942 Lt., Captain October 1943; Service Terminated May 6, 1946; Duty—Stark General Hosp., Charleston, S. C.; School of Clinical Pathology, University of Tennessee; 48th General Hospital—316th General Hospital—317 Station Hospital — 8th Convalescent Hospital — 312th Station Hospital (European Theatre of Operations).

THOMPSON, LLOYD J., New Haven; b. 1895; Washington University 1919; Army—April 1, 1942 Major, Lt. Colonel August 11, 1942, Colonel May 6, 1943; Service Terminated December 22, 1945; Duty—Walter Reed General Hospital, Washington, D. C.; Office of Chief Surgeon, ETOUSA; First Service Command; Awards—1 battle star; Legion of Merit; (Removed to Winston-Salem, N. C.).

THOMPSON, SIDNEY A., Greenwich; b. 1897; Cornell 1923; Navy—October 19, 1942 Lt., Comdr., Commander July 10, 1945; Service Terminated January 5, 1946; Duty—Norfolk, Va.; Elizabeth City, N. C.; USS Freemont (Asiatic-Pacific Theatre of Operations); Memphis, Tenn.

THOMPSON, WALTER A. L., New Haven (Entered service from New York City); b. 1911; Yale 1935; Army—February 25, 1944 Lt., Captain, Major; Service Terminated February 21, 1947; Duty—Walter Reed General Hospital, Washington, D. C.

THORNE, LEWIS, New Haven; b. 1907; Yale 1936; Army—July 15, 1941 Lt., Captain January 1942, Major March 1943; Lt. Colonel December 1945; Service Terminated January 26, 1946; Duty—Lawson General Hospital, Atlanta, Ga.; 10th Mountain Division, Camp Hale, Colo.; Camp Swift, Tex.; (Mediterranean Theatre of Operations); Award—Bronze star.

THUMIM, MARK, Middletown (Entered service from Long Beach, N. Y.); b. 1909; Maryland 1933; Army—June 20, 1941 Lt., Captain February 1, 1942, Major February 27, 1945; Service Terminated April 6, 1946; Duty—Madison Barracks, N. Y., Casablanca, French Morocco (North African Theatre of Operations); Camp Kilmer, N. J.; 1[illegible] General Hospital, New Guinea (Asi[illegible] Pacific Theatre of Operations).

TIMM, ALEXANDER B., JR., Milf[illegible] b. 1913; Harvard 1940; Army—Sep[illegible] ber 1, 1942 Lt., Captain September [illegible] 1943, Major January 14, 1946; Ser[illegible] Terminated July 9, 1946; Duty—[illegible] Riley, Kan.; 54th General Hosp[illegible] Milne Bay, Hollandia, N. G.; Offic[illegible] Chief Surgeon, GHQ, AFPAC Ma[illegible] P. I., and Tokyo, Japan (Asiatic-Pa[illegible] Theatre of Operations); Award—M[illegible] torious Service Unit Plaque.

TINKESS, DONALD E., Greenwich[illegible] 1901; McGill 1925; Army—July [illegible] 1942 Major, Lt. Colonel January [illegible] 1944, Colonel May 10, 1946; Ser[illegible] Terminated July 10, 1946; Duty—[illegible] Jackson, S. C.; 4th General Hosp[illegible] Manila, P. I. (Asiatic-Pacific Theatr[illegible] Operations).

TIRELLA, FRED F., Bristol.

TISSENBAUM, MORRIS J., Norwich[illegible] 1908; Paris (France) 1936; Army—[illegible] tember 15, 1944 Lt., Captain July 1[illegible] Major February 1947: Service Ter[illegible] nated August 19, 1947; Duty—Car[illegible] Barracks, Pa.; Camp Blanding, [illegible] Indiantown Gap, Pa.; Ft. Eustis, [illegible] Camp Lyte, Va.; Valley Forge Gen[illegible] Hospital, Phoenixville, Pa.; Awards 2 Meritorious Unit Awards; (Removed [illegible] New York, N. Y.).

TOMBARI, S. PAUL, Waterford; [illegible] 1908; Boston University 1934; Arm[illegible] April 8, 1944 Lt., Service Termina[illegible] July 31, 1945; Duty—Carlisle Barra[illegible] Pa.; Lawson General Hospital, Atla[illegible] Ga.; Ft. Riley, Kan.; Camp Barke[illegible] Tex.

TONKEN, LOUIS C., Hartford; [illegible] 1908; Tufts 1934; Army—February [illegible] 1943 Lt., Captain January 25, 19[illegible] Service Terminated March 5, 1946; D[illegible] —Continental United States.

TORTORA, FRANK, New Haven; [illegible] 1913; Rome (Italy) 1940; Army—J[illegible] 18, 1943 Lt., Captain January 1, 19[illegible] Service Terminated June 6, 1946; D[illegible] —Camp Blanding, Fla.; European Th[illegible] tre of Operations; Award—1 battle s[illegible]

TOVELL, RALPH M., Hartford; [illegible] 1901; Queens 1926; Army—August [illegible] 1942 Lt. Colonel, Colonel January [illegible] 1945; Service Terminated October [illegible] 1945; Duty—Walter Reed General H[illegible]

, Washington, D. C.; European Theaof Operations; Awards—Legion of t; 1 battle star.

VNSEND, WILMOT C., Hartford; 398; Harvard 1925; Army—Septem-10, 1942 Major, Lt. Colonel April 8, , Colonel December 1945; Service ninated January 27, 1946; Duty— Station Hospital—33rd General Hos- (Mediterranean Theatre of Opera-); Awards—Bronze star; Meritori-Service Unit Plaque.

NTOLO, ARTHUR, East Hartford; 912; Tufts 1939; Army—September 942 Lt., Captain July 1943; Service ninated February 18, 1946; Duty— isle Barracks, Pa.; Okinawa-Korea atic-Pacific Theatre of Operations).

PP, FRANCIS W., New Britain; b. ; Georgetown 1936; Navy—May 12, Lt. (j.g.), Lt. March 1943, Lt. dr. October 1945; Service Termid December 31, 1945; Duty—Washon, D. C.; Base Hospital—Casaca, French Morocco (North African atre of Operations); USS Samuel se; New London, Conn.

FARI, LEOPOLD M., West Hart- (Entered service from Cranston, .); b. 1916; Tufts 1942; Army—July 1943 Lt., Captain July 15, 1944; ice Terminated May 9, 1946 ajor); Duty—46th Field Hospital—tinental United States and European atre of Operations; 348th Station pital (ETO); Awards—3 battle s; Haakon VII Liberty Award.

OY, WILLIAM D., Stamford; b. 1; Jefferson 1936; Army Air—May 6, 3 Lt., Captain February 14, 1944, or July 9, 1946; Service Terminated tember 12, 1946; Duty—Carlisle racks, Pa., Lowry Fld, Colo.; Robins , Ga.

UEX, EDWARD H., JR., Hartford; 1911; Harvard 1936; Army—Septem-10, 1942 Captain, Major June 30, 4; Service Terminated April 1, 1946 . Colonel); Duties—Walter Reed eral Hospital, Washington, D. C.; hon General Hospital, Butler, Pa.; ard—Army Commendation Ribbon.

CKER, CHARLES A., Hartford (Ened service from Boston, Mass.); b. 4; Tufts 1938; Army—December 9, 2 Lt., Captain February 1944, Major ril 1946; Service Terminated September 29, 1946; Duty—Continental United States; Award—Unit Meritorious Service Citation.

TUNICK, GEORGE L., Greenwich; b. 1910; Jefferson 1935; Army—May 20, 1941 Lt., Captain August 15, 1942, Major May 15, 1945; Service Terminated March 24, 1946; Duty—Ft. Devens, Mass.; Camp Blanding, Fla.; Camp Forrest, Tenn.; Camp Phillips, Kan.; Brisbane, Australia; New Guinea; Biak Island, Dutch East Indies; Philippine Islands; Tokyo, Japan (Asiatic-Pacific Theatre of Operations); Awards—Combat Medical Badge; 3 battle stars.

TURCO, VINCENT J., Hartford (Entered service from Westerly, R. I.); b. 1916; Tufts 1941; Army—July 8, 1944 Lt., Captain October 1945, Major December 3, 1946; Service Terminated October 8, 1947; Duty—Carlisle Barracks, Pa.; Lawson General Hosp., Atlanta, Ga.; Murphy General Hospital, Waltham, Mass.; Tilton General Hospital, Ft. Dix, N. J.

TWACHTMAN, ERIC, New Canaan; b. 1909; Virginia 1936; Navy—March 2, 1942 Lt. (j.g.), Lt. October 1, 1942, Lt. Comdr. July 1945; Service Terminated February 5, 1946; Duty—Destroyer Division 67; USS Borie (Atlantic); Philadelphia, Pa.; Farragut, Idaho; Shoemaker, Calif.; New Hebrides and Okinawa (Asiatic-Pacific Theatre of Operations); Awards—2 Letters of Commendation.

TWADDLE, PAUL H., Hartford; b. 1908; Yale 1935; P.H.S. (USCG)—December 26, 1942 P.A. Surgeon, Surgeon June 1, 1944; Service Terminated February 1, 1946; Duty—Sheepshead Bay, N. Y.; USS Mojave; Newport, R. I.

TYLEC, LEO L., Naugatuck; b. 1911; Medical College of Virginia 1935; Army—May 1, 1941 Lt., Captain February 1, 1942; Service Terminated March 17, 1946; Duty—Ft. Devens, Mass.; Camp Edwards, Mass.; Asiatic-Pacific Theatre of Operations; Awards—Bronze star; 2 battle stars.

UNGER, MILTON, Bridgeport; b. 1910; Hahnemann 1937; Navy—July 1941 Lt. (j.g.); Service Terminated December 2, 1941; Duty—Quantico, Va.

UNSWORTH, ARTHUR C., Hartford; b. 1905; Vermont 1931; Army Air—May 27, 1942 Major, Lt. Colonel June 30, 1943; Service Terminated October 21, 1945; Duty—Regional Hospital, Miami, Fla.

UVITSKY, IRVING H., Bridgeport; b. 1901; Boston University 1927; Army—February 25, 1944 Captain, Major June 24, 1946; Service Terminated August 25, 1946; Duty—Carlisle Barracks, Pa.; O'Reilly General Hospital, Springfield, Mo.; Camp Atterbury, Indiana; Camp Lee, Va.; Awards—Army Commendation Ribbon; Meritorious Service Plaque.

VADASZ, EDMOND, Meriden.

VALENSKI, THADDEUS J., Thompsonville; b. 1910; Tufts 1937; Army—September 29, 1942 Lt., Captain January 5, 1944; Service Terminated April 30, 1946; Duty—Africa, France, Italy, Germany (North African-Mediterranean-Middle Eastern Theatres of Operation); Hospital Ship Blanche F. Sigman: Awards—2 battle stars; Meritorious Citation.

VAN ANTWERP, LEE D., Meriden; b. 1900; Michigan 1931; Army—November 20, 1942 Captain, Major December 27, 1943, Lt. Colonel March 1, 1946; Service Terminated June 1, 1946; Duty—Ft. Dix, N. J.; Borden General Hospital, Chickasha, Okla.; Camp Chaffee, Ark.; (Removed to Chicago, Ill.).

VENERUSO, LEONARD C., Bridgeport; b. 1918; New York Medical College 1942; Army Air—July 3, 1943 Lt., Captain October 1944; Service Terminated October 10, 1946; Duty—Jefferson Barracks, Mo.; Scott Fld., Ill.; Award—Army Commendation Ribbon.

VERMOOTEN, VINCENT, New Haven; b. 1897; Johns Hopkins 1923; Army—September 12, 1942 Major, Lt. Colonel November 24, 1945; Service Terminated March 8, 1946; Duty—Brooke General Hospital, Ft. Sam Houston, Tex.; (Removed to Dallas, Texas).

VERNON, SIDNEY, Willimantic; b. 1906; Long Island College of Medicine 1930; Army Air—July 1, 1941 Lt., Captain August 8, 1941, Major September 16, 1945; Lt. Colonel January 8, 1946; Still in Military Service, Ft. Monmouth, N. J.; Duty—Westover Fld., Mass.; Philippines (Asiatic-Pacific Theatre of Operations); Awards—Combat Medical Badge; Bronze star; (Prisoner of War).

VERSTANDIG, CHARLES C., New Haven; b. 1908; Tennessee 1939; Army—August 1, 1940 Lt., Captain April 1941,

Major July 1943, Lt. Colonel September 1945; Service Terminated February 5, 1946; Duty—Ft. Devens, Mass.; Ft. Dix, N. J.; European Theatre of Operations; New Haven, Conn.; Awards—3 battle stars; Combat Medical Badge; Citation, War Shipping Administration; Letter of Commendation; Army Commendation Ribbon w/cluster; Bronze star.

VOGEL, FRANK S., Bristol; b. 1902; Vienna (Austria) 1927; P.H.S.—June 6, 1945 Major; Service Terminated November 21, 1946; Duty—Washington, D. C.; London, England; Salzburg, Linz, Vienna, Austria.

VON GLAHN, HAROLD D., Old Lyme (Entered service from New York City); b. 1915; Duke 1942; Navy—January 10, 1944 Lt. (j.g.); Lt. May 1946; Service Terminated August 11, 1946; Duty—Naval Shipyard, New York City; USS Dallas (American and European Theatres of Operation); Award—1 battle star.

VORIS, JACQUES V. B., Darien; b. 1912; Columbia 1941; Army—July 1, 1942 Lt., Captain February 9, 1943; Service Terminated February 10, 1946; Duty—Ft. Sam Houston, Tex.; Camp Swift, Tex.; 334th Station Hospital—Milne Bay and Hollandia, N. G. (Asiatic-Pacific Theatre of Operations).

WALKER, DONALD A., Rocky Hill (Entered service from Worcester, Mass.); b. 1912; Tufts 1938; Army—November 24, 1941 Lt., Captain September 19, 1942; Service Terminated December 29, 1945; Duty — African-Middle Eastern Theatres of Operations.

WALKER, ROBERT, Hartford; b. 1910; Rochester 1937; Army Air—July 1, 1941 Lt., Captain June 1942, Major November 1943; Service Terminated December 23, 1945 (Lt. Colonel); Duty—Bradley Fld., Conn.; Rentschler Fld.; School of Aviation Medicine, Randolph Fld., Tex.; 373rd Fighter Group—European Theatre of Operations; Awards—Soldiers Medal; Presidential Unit Citation; Belgian Fourragiere; Letter of Commendation.

WALLACE, VICTOR G. H., Norwalk; b. 1897; Edinburgh (Scotland) 1926; Army Air—June 8, 1942 Major, Lt. Colonel April 1945; Service Terminated September 23, 1945; Duty—General Staff School, Ft. Leavenworth, Kan.; School of Aviation Medicine, Randolph Fld., Tex.; Flight Surgeon; Dover Army Air Base; 1st Air Force, Mitchell Fld., N. Y.

WARD, JAMES P., Bridgeport.

WATSON, ROBERT W., Manchester (Entered service from Los Angeles, Calif.); b. 1913; Wisconsin 1938; Army—April 24, 1942 Lt., Captain 1943; Service Terminated January 21, 1946; Duty—Blood Donor Service, Los Angeles, Calif.; Washington, D. C.; Ft. Benning, Ga.; Ft. Jackson, S. C.; European Theatre of Operations.

WATSON, WILLIAM J., New Britain; b. 1907; New York University 1931; Navy—March 20, 1944 Lt. Comdr.; Service Terminated March 10, 1946; Duty—Portsmouth, Va.; Coco Sola, C. Z.; Newport, R. I.

WEBER, FREDERICK C., JR., Greenwich; b. 1911; Johns Hopkins 1936; Army—July 15, 1942 Captain, Major February 14, 1944, Lt. Colonel August 4, 1945; Service Terminated February 14, 1946; Duty—Harbor Defenses of Boston, Mass.; School of Tropical Medicine; Asiatic-Pacific Theatre of Operations.

WEED, CHESTER A., New Haven (Removed).

WEIGLE, LUTHER A., JR., New Haven; b. 1914; Yale 1939; Navy—March 16, 1942 Lt. (j.g.), Lt. October 1, 1942, Lt. Comdr. July 29, 1945; Service Terminated December 11, 1945; Duty—Hdq. 3rd Naval District; USS American Legion; Magenta Air Fld, New Caledonia (Asiatic-Pacific Theatre of Operations); Brooklyn Navy Yard, N. Y.; U. S. Merchant Marine Academy, Kings Point, N. Y.; Camp Lejeune, N. C.; (Removed to Newport, N. H.).

WEINSTEIN, NATHAN, Norwalk; b. 1905; Trinity College, Dublin (Ireland) 1934; Army—January 6, 1943 Captain; Service Terminated March 15, 1946; Duty—Camp Reynolds, Pa.; 195th General Hospital—European Theatre of Operations; Ft. Dix, N. J.; Atlantic City, N. J.; Award—1 battle star.

WEISENFELD, NATHAN, Hartford; b. 1901; Maryland 1928; Army—June 15, 1942 Captain, Major 1945; Service Terminated March 7, 1946; Duty—Carlisle Barracks, Pa.; European Theatre of Operations; Awards—2 battle stars.

WELLS, JOHN B., Wethersfield; b. 1913; Yale 1940; Navy—April 11, 1941 Lt. (j.g.) USNR, Lt. (j.g.) February 1941, Lt. June 1942, Lt. Comdr. 1943; Commander November 1945; Service Terminated March 5, 1946; Duty—Sub. B New London, Conn.; Naval Hosp., Pl delphia, Pa.; USS Plunkett; USS M rant; Lahey Clinic, Boston, Mass.; N Hosp., Camp LeJeune, N. C.

WELT, LOUIS G., New Haven; b. 1 Yale 1938; Army—July 1, 1942 Captain September 16, 1943, Major tember 14, 1945; Service Termin March 4, 1946; Duty—39th Gen Hospital, Auckland, N. Z.; Guadalca Green Island, Bougainville, Leyte, C Luzon, P. I.; American Division; Aw —Bronze star; Asiatic-Pacific The Ribbon w/3 battle stars; Philipp Liberation Ribbon w/1 battle star; moved to Washington, D. C.).

WENTWORTH, JOHN H., New Ha b. 1914; Yale 1939; Army—Septem 20, 1940 Lt., Captain June 2, 1942, M February 12, 1943, Lt. Colonel Decem 23, 1945; Service Terminated Januar 1946; Duty—Ft. Devens, Mass.; Spr field, Mass.; Foster Fld., Tex.; Redistr tion Station #3, Santa Monica, Ca Kelly Fld., Tex.; (Removed to Ashv North Carolina).

WESTON, ROBERT A., JR., Mil (Entered service from Baltimore, M b. 1916; Harvard 1941; Army—Sept ber 14, 1944 Lt., Captain June 15, 1 Major November 8, 1946; Service Te nated August 13, 1947; Duty—Car Barracks, Pa.; 85th Evacuation Hosp —195th General Hospital—317th tion Hospital (European Theatre Operations); Ft. Jay, N. Y.

WHALLEY, EVAN J., Waterbury tered service from Pawtucket, R. I.) 1918; Tufts 1943; Army—January 1944 Lt., Captain June 1945; Ser Terminated May 1946; Duty—Car Barracks, Pa.; Thayer General Hosp Nashville, Tenn.; Stark General Ho tal, Charleston, S. C.; 24th Station H pital—234th General Hospital (Ch Burma-India Theatre of Operations).

WHITCOMB, BENJAMIN B., Hartf b. 1908; McGill 1935; Army—June 1943 Lt., Captain February 1944, M July 1945; Service Terminated Marc 1946; Duty—Walter Reed General H pital, Washington, D. C.; Halloran C eral Hospital, Staten Island, N. Y.

WHITE, BENJAMIN V., Hartford; 1908; Harvard 1934; Navy—Decem 21, 1942 Lt., Lt. Comdr. October 1 Service Terminated May 9, 1946; Dut

al Medical School, Bethesda, Md.; al Recruiting Station, Richmond, USS Benevolence (Asiatic-Pacific atre of Operations).

ITE, EDWARD P., Hartford; b. 1; Vermont 1937; Navy—May 30, 2 Lt. (j.g.), Lt. March 1943, Lt. ndr. October 1945; Service Termi- d December 14, 1945; Duty—Balboa, Z.; Chelsea, Mass.; R.O.T.C. Harvard versity, Cambridge, Mass.; Base Hos- l #2 and C.B.D. 1050 (Asiatic- ific Theatre of Operations).

ITE, JOHN C., New Britain; b. 2; Harvard 1929; Navy—October 25, 3 Lt. Comdr., Commander November 1945; Service Terminated March 4, 6; Duty—St. Albans, N. Y.; Norfolk, ; Scotland (European Theatre of Op- ions); Ft. Eustis, Va.; A.P.A. 167 cific); Pearl Harbor, T. H.; Saipan, I.; Aiea Heights, T. H.; (Asiatic- ific Theatre of Operations).

ITE, ROBERT M., New Haven; b. 3; Harvard 1939; Army—October 10, 2 Lt., Captain February 1944, Major rch 1945; Service Terminated March 1946; Duty—Lovell General Hosp., Devens, Mass.; Camp Upton, N. Y.; Dix, N. J.; 157th General Hospital— th General Hospital—91st General spital (European Theatre of Opera- ns).

ITING, HERBERT S., Hartford moved).

EPERT, WILLIAM M., Avon; b. 2; Yale 1937; Army—August 11, 1942 Captain April 8, 1943, Major March 1945; Service Terminated December 1945; Duty—Carlisle Barracks, Pa.; np Campbell, Ky.; Ft. Ord, Calif.; ka; European Theatre of Operations.

ES, CARL H., New London; b. 1906; le 1932; Army—March 12, 1941 Cap- n, Major January 1942, Lt. Colonel tober 1942; Service Terminated No- nber 15, 1945; Duty—Ft. H. G. ight, N. Y.; European Theatre of Op- tions; Awards—Pre-Pearl Harbor Rib- n; 5 battle stars.

IES, FREDERICK A., New Haven; b. 08; Yale 1933; Army—July 15, 1942 ptain, Major 1945; Service Terminated ruary 6, 1946; Duty—139th General spital—Camp Edwards, Mass.; Auck- d, N. Z.; Saipan, M. I. (Asiatic-Pacific eatre of Operations); Award—1 battle r.

WILCOX, FREDERICK C., JR., Waterbury; b. 1909; College of Medical Evangelists 1934; Navy—November 23, 1942 Lt., Lt. Comdr. July 20, 1945; Service Terminated February 19, 1946; Duty—Sampson, N. Y.; L.S.T. 310—European Theatre of Operations; Fleet Hospitals #115—107 (Asiatic-Pacific Theatre of Operations); Award—Unit Citation.

WILLARD, WILLIAM R., New Haven (Entered service from Hagerstown, Md.); b. 1908; Yale 1934; P.H.S. Army —February 21, 1944 Major; Service Terminated July 21, 1946; Duty—Military Government Training Schools—Charlottesville, Va.—Yale University, New Haven, Conn.; Presidio of Monterey, Calif.; Korea, Japan (Asiatic-Pacific Theatre of Operations).

WILLIAMS, EDWARD E., Naugatuck; b. 1897; Columbia 1923; Army—July 5, 1941 Major, Lt. Colonel November 30, 1945; Service Terminated March 19, 1946; Duty—Ft. Banks, Mass.; Cushing General Hospital, Framingham, Mass.; 102nd General Hospital—117th General Hospital—94th General Hospital—9th Field Hospital—England and France (European Theatre of Operations); Ft. Monmouth, N. J.

WILLIAMS, FRANCIS P. A., Monroe; b. 1911; New York Medical College 1944; Navy—July 20, 1945 Lt. (j.g.); Service Terminated June 26, 1946; Duty —Treasure Island Naval Hospital, Calif.; 19th Fleet, San Diego Group; Award—Letter of Commendation.

WILLIS, THAYER, Norwalk.

WILLS, ARTHUR A., JR., Hartford (Entered service from Braintree, Mass.); b. 1905; Yale 1931; Navy—March 19, 1942 Lt., Lt. Comdr. July 10, 1945; Service Terminated January 21, 1946; Duty—First Naval Ditsrict; USS Niagara; Blood Donor Center, Hartford, Conn.; USS Tuscana (Asiatic-Pacific Theatre of Operations); Davisville, R. I.; Awards—2 battle stars.

WILSON, ARCHIBALD C., Hartford; b. 1908; Toronto 1934; Navy—February 8, 1943 Lt., Lt. Comdr. October 3, 1945; Service Terminated April 1, 1946; Duty—Bureau of Medicine and Surgery, Division of Physical Qualifications, Washington, D. C.; Award—Letter of Commendation, Surgeon General, USN.

WILSON, GEORGE C., Wallingford; b. 1902; Yale 1928; Navy—September 5, 1941 Lt. Comd., Commander February 11, 1944; Service Terminated October 3, 1945; Duty—Brooklyn, N. Y.; Naval Air Station, Pensacola, Fla.; Norman, Okla.; Flight Surgeon USS Rudyard Bay (Asiatic-Pacific Theatre of Operations); Quonset Pt., R. I.; (Removed to Waban, Mass.).

WILSON, WILLIAM A., Hartford; b. 1903; Louisville 1928; Navy—December 9, 1942 Lt., Lt. Comdr. September 2, 1942, Commander July 10, 1945; Service Terminated February 1, 1946; Duty—Norfolk, Va.; New Orleans, La.; Moffet Fld., Calif.; Base Unit #7—Guadalcanal and Bougainville (Asiatic-Pacific Theatre of Operations); National Naval Medical Center, Washington, D. C.

WILSON, WILLIAM R., New Haven; b. 1898; Johns Hopkins 1925; Navy—April 17, 1942 Lt. Comdr., Commander March 1, 1944; Service Terminated December 3, 1945; Duty—Sub. Base, New London, Conn.; Solomons, Md.; Norfolk, Va.; USN Mobile Hospital #12; Acorn 36; USNAB 939 Oroto Peninsula, Guam (Asiatic-Pacific Theatre of Operations).

WINTERS, HYMAN W., Bristol.

WINTERS, JOHN T., Hartford; b. 1905; Pennsylvania 1931; Navy—March 1, 1943 Lt. Comdr., Commander November 1945; Service Terminated January 21, 1946; Duty—Brooklyn, N. Y.; Lido Beach, N. Y.; Base II, Roseneath, Scotland—London, England (European Theatre of Operations); Portsmouth, N. H.

WOLFSON, DEXTER, Bethel; b. 1907; Boston University 1933; Army Air—November 22, 1943 Lt., Captain November 1, 1945; Service Terminated September 24, 1946; Duty—McDill Fld., Fla.; 20th Armored Division—Camp Campbell, Ky.—France, Germany; 116th General Hospital, Nurnberg, Germany European Theatre of Operations).

WOOD, HORATIO C., III, Wilton; b. 1904; Pennsylvania 1938; Army Air—July 2, 1943 Captain, Major April 1946; Service Terminated July 2, 1946; Duty—Carlisle Barracks, Pa.; Kearns, Utah; Ephrata, Wash.; Blythe, Calif.; Walla Walla, Wash.; Geiger Fld, Wash.; Ft. Logan, Colo.; (Removed to Peoria, Ill.).

WOODRUFF, LORANDE M. (Removed to Belmont, Mass.).

To be Continued

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

Poliomyelitis Facilities in Connecticut

DIAGNOSIS

A physician may request assistance in diagnosis from the local health officer. At the request of the health officer, a physician from the bureau of preventable diseases of the state department of health will visit the patient for diagnostic or epidemiological study.

HOSPITALIZATION FACILITIES

Acute cases—Most patients are hospitalized during the acute state of illness. The isolation hospitals in Connecticut are the John James McCook Memorial Hospital, Hartford; the New Haven Hospital; Englewood Hospital, Bridgeport; the Mitchell Ward of the Lawrence Memorial Hospital, New London; the Stamford Hospital and the Nathaniel Witherell Hospital, Greenwich.

Any general hospital may set up an isolation unit for patients with acute poliomyelitis. When general hospitals plan to set up facilities for care of patients with poliomyelitis, it is only natural they should make as many of the important services available as possible through their own resources. Many general hospitals have on their staff, physicians, orthopedists, nurses and physical therapists who have had experience in treating patients with poliomyelitis.

When hospitals do not have trained personnel on their staff, the state department of health will give consultation, assist in securing personnel and furnish personnel during an emergency until trained personnel can be secured, in so far as this is possible.

Convalescent patients—Patients are discharged from isolation hospitals to convalescent institutions or other convalescent facilities for treatment as soon as the quarantine period is over, depending upon the condition of the patient and upon availability of convalescent facilities. For example, if a patient is too ill to be moved, or if convalescent facilities are for the moment not available, he may be cared for in the general hospital associated with the isolation unit. The special facilities providing convalescent care for patients are as follows: the John James McCook Memorial Hospital, Hartford; Newington Home and Hospital for Crippled Children; the Children's Center, Hamden; and the Englewood Hospital, Bridgeport.

These convalescent institutions provide pediatric, medical, orthopedic, nursing and physical therapy services. Some of these institutions also provide the services of medical social workers and occupational therapists.

Convalescent care may also be provided in the patient's own home. Decision to plan for such care on discharge from the hospital would depend upon medical recommendations, social study and existing medical, nursing and social resources.

FOLLOW-UP SERVICES

After discharge from the hospital or convalescent home, follow-up services, (such as medical, orthopedic, physical therapy, public health nursing, etc.) may be provided through the patient's physician, or at orthopedic or special poliomyelitis clinics.

Clinic Services—Under the auspices of the Hartford County Chapter of the National Foundation for Infantile Paralysis, a monthly clinic is held at the Hartford Hospital. At this clinic patients are followed who were hospitalized at the Isolation and Convalescent units of the McCook Hospital or who were treated at home.

New Haven Hospital orthopedic clinic furnishes services for patients from New Haven County and part of Fairfield County.

The Physical Therapy Clinic of the Bridgeport Chapter of the Connecticut Society for Crippled Children and Adults gives services to children living in Bridgeport and surrounding towns.

Newington Home and Hospital for Crippled Children receives patients referred from various parts of the state for care following the isolation period. It gives follow-up services through its clinics at the Home.

Clinics of the division of crippled children of the state department of health care for patients, on referral, who have been discharged from hospitals or

convalescent homes and are living in areas close to the clinics. These clinics are conducted monthly in the following hospitals:

Danbury ..... Danbury Hospital
Derby ..... Griffin Hospital
Norwich ..... William W. Backus Hospital
Putnam ..... Day Kimball Hospital
Stamford ..... Stamford Hospital
Torrington ..... Charlotte Hungerford Hospital
Willimantic ..... Windham Community Memorial

In some instances children are given medical care by a local hospital or clinic but the state department of health may still be requested to supply other related services such as nursing, physical therapy and medical social services.

Physical Therapy—Physical therapy services are available through hospitals, convalescent institutions, clinics, or state physical therapy centers in the following cities and towns.

TOWN	LOCATION OF PHYSICAL THERAPY FACILITIES
Bridgeport	Bridgeport Hospital, St. Vincent's Hospital, Englewood Hospital, The Physical Therapy Clinic of the Bridgeport Chapter of the Connecticut Society for Crippled Children and Adults, Bridgeport
Danbury	Danbury Hospital†
Derby	Griffin Hospital*
Hamden	Children's Center
Hartford	John James McCook Memorial Hospital, St. Francis Hospital, Hartford Hospital
Meriden	Meriden Hospital
Middletown	Middlesex Hospital
Monroe	Monroe School*
Naugatuck	Naugatuck Red Cross*
New Britain	New Britain General Hospital
New Haven	New Haven Hospital, Grace Hospital
Newington	Newington Home and Hospital for Crippled Children
New London	New London Health Department*
New Milford	New Milford Visiting Nurse Association*
Newtown	Visiting Nurse Association*
Norwalk	Norwalk Hospital
Norwich	William W. Backus Hospital†
Plainfield	Public Schools in Plainfield and Moosup*
Putnam	Day Kimball Hospital*
Rockville	Rockville City Hospital*
Stafford Springs	Visiting Nurse Association*
Stamford	Stamford Hospital,* St. Joseph's Hospital
Thomaston	Visiting Nurse Association*
Thompson	St. Joseph's School, North Grosvenordale*
Torrington	Charlotte Hungerford Hospital†
Waterbury	St. Mary's Hospital, Waterbury Hospital†
Waterford	Waterford School*
Watertown	Visiting Nurse Association*
Winchester	Winsted Visiting Nurse Association†
Windham	Windham Community Memorial Hospital, Willimantic†

*State Technician
†State and Hospital Technicians

RESPIRATORS IN CONNECTICUT

There are over 30 respirators located at various hospitals throughout the state. In addition, the state department of health has four respirators that can be obtained on loan.

A supply depot is maintained in Boston by The National Foundation for Infantile Paralysis from which respirators, machines for preparing hot packs and material for packs can be furnished within 24 hours in case of need. In order to obtain this equipment contact The National Foundation for Infantile Paralysis, 120 Broadway, New York City. When ordering a respirator from any source check whether the machine requires DC or AC current.

FINANCIAL ASSISTANCE

Financial assistance for individual care of patients with poliomyelitis may be obtained by applying to the County Chapters of the National Foundation for Infantile Paralysis. The physician or family may communicate with the chairman of his County Chapter or with the state office of the Foundation at 36 Pearl Street, Hartford. The following is the list of the chairman of the various chapters:

CHAPTER	CHAIRMAN	ADDRESS
Fairfield County	Judge Paul V. Cavanaugh	P. O. Box 206, Newtown
Hartford County	David A. Wilson	75 Pearl Street, Hartford
Litchfield County	Roy Hudson	Torrington National Bank, Torrington
Middlesex County	James L. Montgomery	252 Main Street, Middletown
New Haven County	Prof. Ira V. Hiscock	Yale University, Dept. of Public Health, New Haven
New London County	Charles W. Cassidy	10 Shetucket Street, Norwich
Tolland County	Arthur Sebert	451 Connecticut Blvd., East Hartford
Waterbury Chapter	Edward J. Godfrey, M.D.	Municipal Building, Waterbury
Windham County	Napoleon C. Bortolan	826 Main Street, Willimantic

CORRESPONDENCE

Requests for Continued Treatment Coming In Late

Veterans Administration Regional Office
95 Pearl Street, Hartford 4, Connecticut

To the Secretary of the Connecticut State Medical Society:

We are in receipt of a teletype from our Central Office advising that "Requests for Continued Treatment" should be received by Regional Offices, when possible, not later than five days prior to the expiration of the authority for treatment for which continuation is requested. Except in emergencies, no continuing treatment may be rendered without prior authorization.

In this connection, it has been our experience that approximately 60 per cent of our fee-basis physicians do submit Section IV, VA Form BO-10-9005, Request for Continued Treatment, at least five days prior to the expiration date of authorization for treatment, for which continuation is requested. However, approximately 20 per cent of the physicians submit the renewal request from one to ten days late, and the remaining 20 per cent from ten to twenty days late.

Effective upon release of this letter, this office will be compelled to strictly enforce the regulation quoted in paragraph one above. It is our desire to bring to the attention of all fee-basis physicians the importance of submitting the request for continued treatment at least five days prior to the first day of the month for which continued treatment is being requested.

The submission of Section IV, VA Form BO-10-9005 should not, repeat, should not, be delayed until the end of the month and submitted with the Statement of Services Rendered. This point cannot be over-emphasized. If Section IV is not submitted prior to the first day of the month for which continued treatment is being requested, the effective date of authorization will be the date that the request for continued treatment is received in this office.

It would be appreciated if this information could be disseminated to our fee-basis physicians through the medium of the CONNECTICUT STATE MEDICAL JOURNAL. I would also like to express to you, to th Committee for Medical Care of Veterans, and to a fee basis physicians, my sincere appreciation for th splendid cooperation shown in the Home Tow Medical Care Plan.

Without the joint efforts of all concerned, ou plan of first rate medicine to our veterans cann succeed.

S. A. Schuyler, M.D.,
Chief Medical Offic

South Dakota Calls

Veterans Administration Hospital
Fort Meade, South Dakota

To the Editor:

This station, a Veterans Administration Neur psychiatric Hospital of 720 beds, located in the foo hills of the beautiful Black Hills vacationland c South Dakota, has six immediate vacancies in th positions of Doctor in the Department of Medicir and Surgery ranging in salary from $4,479.60 t $8,509.50 depending upon qualifications and exp rience requirements.

The basic requirement for a doctor in the Depar ment of Medicine and Surgery are as follows:

A. Must be a citizen of the United States.

B. Must hold a degree of doctor of medicine fro an approved college or university, and have com pleted an approved internship. The approve schools of medicine and hospitals for internshi shall be those listed by the Council of Medic Education and Hospitals, American Medical Asso ciation in the list published for the year in whic the course of study for internship was completed b the applicant.

C. Must be licensed to practice Medicine or Su gery in a State or Territory of the United States District of Columbia.

D. Must meet the necessary physical standards f appointment.

E. Must be less than 55 years of age unless h possesses unusual professional or administrativ qualifications.

Applicants must show civil and/or military pra tice in the profession in the amounts shown belo In each case, the required periods of time inclu time spent in internship. The table below also po

rays the minimum and maximum salary for each grade.

GRADE	MINIMUM SALARY	MAXIMUM SALARY	MINIMUM EXPERIENCE REQUIREMENT
Junior	$4,479.60	$5,232.00	Internship only
Associate	5,232.00	6,235.20	3 years
Full	6,235.20	7,192.80	5 years
Intermediate	7,432.20	8,389.80	7 years
Senior	8,509.50	9,706.50	8 years

The above salaries shall be increased by 25 per cent if the applicant is certified as a specialist by an American Specialty Board recognized by the Administrator of Veterans Affairs.

Fort Meade Hospital is located one and a half miles from Sturgis, South Dakota, a city of approximately 5,000 population. Sturgis has an excellent public school system and also an excellent Catholic school, St. Martin's Academy. A bus from Fort Meade takes the school children to and from school. Sturgis is a city of churches having the various Protestant denominational and Catholic churches. Rapid City with a population of approximately 25,000 is located 30 miles from Fort Meade. Two colleges are located within a radius of 30 miles from Fort Meade, the Black Hills Teacher's College at Spearfish and the School of Mines (one of the finest of its type in the United States) at Rapid City.

Quarters for doctors are located on the station at prices ranging from $630 to $780 per annum. These quarters are comfortably and adequately furnished and included in the per annum cost are all utilities. Fort Meade itself possesses various recreational facilities such as bowling alleys, a tricky nine hole golf course, movie theater, swimming pool, soft ball and base ball diamonds, gymnasium and library.

The Veterans Administration offers unusual opportunity for study and further education for those doctors who are interested in making psychiatry their career.

We would greatly appreciate it if this matter was brought to the attention of the physicians who will appear before the next Board of Medical Examiners as we desire to augment our staff with capable and competent doctors interested in the field of psychiatry.

Please advise any doctor interested to address inquiries to the personnel officer this station.

T. H. Fox, M.D.,
Acting Chief, Professional Services

First National Medical Public Relations Conference Scheduled

A national medical public relations conference, first of its kind, which will tackle 6 common objectives facing the medical profession today is to be held in St. Louis on November 27. Dr. George F. Lull, secretary-manager of the American Medical Association, announced that his office will sponsor the meeting.

"Shooting at Common Targets in Medical Public Relations" is the theme of the conference to which will be invited public relations directors, executive secretaries charged with public relations duties and public relations committee chairmen from each of the 48 state medical societies.

Featured for luncheon and dinner talks will be noted and qualified speakers on the following topics: "The Public Speaks on Health," "What Public Relations Did for Us" and "Yes, the Profession Needs PR."

At the workshop session which will be run in the afternoon from two to five o'clock, carefully selected discussion leaders from the state societies will grapple with these 6 major social issues facing the medical profession: selling the need of public relations to state medical society members, encouraging wider use of medical prepayment plans, setting up workable systems for handling night calls, the rebate problem, developing goodwill with labor, farm, industrial and co-op groups, and cooperating with health agencies.

The conference will immediately precede the annual secretaries-editors meeting, which is being held in conjunction with the annual Interim Session of the American Medical Association, November 28 to December 3.

Dr. Lull declared that the planning and guiding of the conference would be handled by Lawrence W. Rember, William Doscher and John Bach of the Association's public relations staff.

"Question and answer periods will follow each workshop topical presentation," said Lull, "which will enable all those attending to find the best refined answers to common medical public relations problems. We'll get the greatest possible value, because the speakers chosen for the panel have worked out case history solutions on the firing line of their own state and county society experience."

About 100 representatives of state societies are expected to attend the sessions in St. Louis.

WANTED

HUGO BOB HUBSCH, with aliases, Hugo Hubsch, Hugh Hubsch, H. B. Hobsch, Hogo Hobsch, Robert C. Glass, R. C. Harris, Louis S. Miller—FUGITIVE NATIONAL STOLEN PROPERTY ACT IMPERSONATION

The Federal Bureau of Investigation is presently seeking the apprehension of HUGO BOB HUBSCH in connection with his issuance of numerous worthless checks in violation of the National Stolen Property Act. An indictment was returned by the Federal Grand Jury at Jackson, Mississippi, on November 7, 1945, charging him with having transported or caused to be transported in interstate commerce two worthless checks drawn on the Fulton National Bank of Atlanta, Georgia and signed by HUBSCH with the fictitious name of R. C. GLASS. A warrant in connection with this matter is presently outstanding against HUBSCH for this activity.

HUBSCH has been particularly active in recent months throughout the eastern and southeastern portions of the United States, including Washington, D. C., Georgia, Florida, Mississippi and Tennessee. He has frequently victimized both doctors and hospitals by issuing worthless checks to them in payment for medical examinations and narcotic prescriptions HUBSCH has been reported to be a narcotic addict.

In May 1948 a reputable medical practitioner examined HUBSCH and found that he has a very large kidney stone in the right ureter about 4 inches below the kidney which has set up considerable local inflammation. This condition was reported by the doctor to cause HUBSCH unbearable pain. The stone is said to be far too large to be passed through normal elimination channels, and the doctor was of the opinion that in the near future it would be an absolute necessity for HUBSCH to undergo major surgery for the removal of the stone.

The modus operandi employed by HUBSCH has, in the past, entailed his contacting either a doctor or a hospital for medical examination and/or treatment. He has, on occasion, impersonated a Federal employee and has also represented himself as a private citizen, using one of the various mentioned aliases. In the course of his contacts with hospitals and doctors, he is often successful in securing prescriptions for certain drugs and he has then tendered worthless checks in payment for the services rendered.

HUGO BOB HUBSCH is described as follows:

Race—White.

Sex—Male.

Age—About 50 years, birth date variously reported as August 22, 1895; November 4, 1900; November 4, 1895; October 4, 1891; November 4, 1897; November 4, 1899; November 4, 1889. Birthplaces have been given as New York, N. Y. and Austria-Hungary.

Height—5′ 4″ to 5′ 7″.

Weight—125 to 170 lbs.

Build—Medium to stocky.

Hair—Dark brown or black, possibly graying.

Eyes—Brown.

Complexion—Variously reported as fair to dark sallow.

Marital status—Probably single.

Occupation—Laborer, pharmacist.

Scars and marks—Needle scars right and left arms; large diagonal scar above each hip from kidney operation; shrapnel and liquid fire scars on abdomen; long 6-inch vertical scar left side of back; 2 bullet holes in stomach; shrapnel wounds on back; large scars on both sides of abdomen and back above kidneys.

Teeth—Bridgework upper front teeth.

Peculiarities—Left arm partly paralyzed, chin square and indented, has stooped or hunchbacked posture, long nose which bends left and then right, has heavy eyebrows which meet in the middle, possible drug addict.

Nationality—American-Jew, Hungarian or French.

Inasmuch as it is highly probable that HUBSCH will require expert medical attention, a major operation and hospitalization in connection with his kidney condition in the near future, it is requested that a lookout be maintained for an individual answering the above description and diagnosis, and that the nearest office of the Federal Bureau of Investigation be notified at once in the event of his appearance: for Connecticut, John J. Gleason, Special Agent in Charge F.B.I., 510 Trust Co. Bldg., New Haven. Phone 7-1217.

SPECIAL NOTICES

ANNOUNCEMENT OF POSTGRADUATE COURSES AT YALE SCHOOL OF MEDICINE

The Yale University School of Medicine announces a series of short postgraduate courses for the academic year 1948-49 as a result of a cooperative program with the Connecticut State Medical Society. A brief description of the course offerings for the coming year follows. These courses are designed to give physicians an opportunity to become familiar with new knowledge, procedures, and points of view, and to assist them in practicing better medicine. It is not expected that these courses will be recognized by Specialty Boards as meeting any of the formal requirements for Board Certification. Because the enrollment in most courses is limited, Connecticut physicians will be given preference. A course will not be offered if the enrollment is too small to justify the expense involved.

To enroll in a course, a physician must fill out an application form which may be obtained from the office of the Assistant Dean in charge of Postgraduate Medical Education. Enrollment may be effected by mail or in person at Room L204, Sterling Hall of Medicine.

Fees are charged for postgraduate courses as indicated under each course. These fees are payable in advance, and should be submitted with the application form. Fees will be refunded if a registration is not accepted, or if a scheduled course is cancelled for any reason. The fees listed for each course cover the entire cost. There are no extra charges. Checks should be made payable to Yale University and mailed to the Assistant Dean in charge of Postgraduate Medical Education. Yale University does *not* have a contract whereby the Veterans Administration will pay the tuition for these postgraduate courses.

Most courses for the academic year 1948-49 will be held in the buildings of the Yale University School of Medicine or on the wards and clinics of the Grace-New Haven Community Hospital (University Service).

Physicians who attend 80 per cent or more of the scheduled meetings of a course will, upon request, be given a Certificate of Attendance.

COURSES OFFERED

ANATOMY 104—DEMONSTRATIONS IN ANATOMY

Prepared dissections will be demonstrated once each week Cross sections, x-ray films, and models are used to supplement dissections and discussions. The following sequence is followed: Thorax, abdomen, head and neck, pelvis, lower extremities, back and upper extremities. Sept. 27, 1948—June 3, 1949. One period each week, days to be arranged, except during academic vacation periods. 7 to 9 P. M. Sections of 8 students each on different nights of the week. Enrollment limited. Resident staff of hospitals given preference. Doctors W. U. Gardner, T. R. Forbes, R. V. Fuldner. C300 SHM. Fee $150.

ANATOMY 201—SPECIAL DISSECTIONS IN ANATOMY

Insofar as space and material permit opportunities will be provided for special dissection by those desiring such study. Instruction will be minimal as it is assumed that the dissector will have adequate background to progress satisfactorily on his own initiative. Arrangements may be made for tutors. No special time is scheduled for this course although more space is available during the summer. Fees will be charged to meet costs of material and expenses. Dr. W. U. Gardner and Staff. Anatomy laboratories, 3rd floor, Wing C SHM.

ANESTHESIOLOGY 200

This course is an orientation program for part time physician anesthetists. Principles of physiology and pharmacology applicable to anesthesia with laboratory demonstrations will be presented by the Department of Pharmacology, Yale University School of Medicine, in the afternoon sessions. Clinical demonstrations and discussions will be conducted by the Departments of Anesthesiology of the Hartford Hospital and Grace-New Haven Community Hospital in the morning sessions. 8 all-day sessions, 6 hours each. Doctors W. T. Salter, R. M. Tovell and Staffs. Mondays Oct. 11—Nov. 1, 1948 at Grace-New Haven Community Hospital (University Service) and Yale University School of Medicine. Tuesdays Nov. 9—Nov. 30, 1948 at the Hartford Community Hospital, Hartford. 7:30 A. M. to 4:30 P. M. Initial meeting room Farnam Operating Room, Grace-New Haven Community Hospital. Minimum enrollment 6; maximum 10. Fee $125.

BRAIN TUMOR REGISTRY

Opportunity is available for properly prepared students specializing in neurosurgery, neurology, psychiatry and neuropathology, to study in the Brain Tumor Registry. Only full time students in limited numbers can be accommodated by individual arrangement. The Registry consists of several thousand specimens of brain and spinal cord

tumors and other diseases of the nervous system. Also available for study are related clinical records, particularly those of Dr. Harvey Cushing's patients, and an extensive collection of books and reprints. Material demonstrating classical examples of various types of intracranial tumors will be studied, and once a week a neurosurgical—neuropathological conference will be conducted in the Registry during which current specimens from the neurosurgical service in the Grace-New Haven Community Hospital will be reviewed from the standpoint of diagnosis and prognosis. Dr. L. Eisenhardt. B109-111 SHM. Fee $65 per month.

MEDICINE 200—CARDIOVASCULAR DISEASE

This course will cover the recent advances, current knowledge of diagnosis and treatment, and practical aspects of handling patients. Attention will be given to such special techniques as electrocardiography, catheterization of the heart and surgical treatment of special cardiac conditions. 12 sessions of 2 hours each. Doctors H. M. Marvin, A. J. Geiger and others. March 10—May 26, 1949. Thursdays 10-12 A. M. Far. A. Minimum enrollment 20; maximum 30. Fee $45.

MEDICINE 201—GASTROENTEROLOGY

This course will give particular attention to diseases of the gastrointestinal tract and interrelationships to diseases in other organs such as the heart and urinary tract. Present concepts, new developments in therapy and diagnostic techniques will be discussed. Esophageal disorders, gastritis, gastric and duodenal ulcer, disorders of the gall bladder, liver, large and small bowel, neoplasms, emotional aspects of gastrointestinal diseases, will be covered. 12 sessions, 2 hours each. Doctors S. D. Kushlan, N. Canfield, L. N. Claiborn, C. L. Deming, A. J. Geiger, G. Klatskin, H. M. Marvin, B. E. Moore, B. V. White. Sept. 23—Dec. 16, 1948. Thursdays except Nov. 25. Fit. A. Minimum enrollment 20; maximum 30. Fee $45.

MEDICINE 202—METABOLISM

The metabolism section of the Department of Medicine is prepared to offer a course on metabolic diseases to be given at community hospitals, upon invitation from the hospital staff. This course is intended as an opportunity for instruction of the hospitals' resident and attending staffs, and the physicians in the community. The content and schedule of the course will be decided in consultation with the committee from the hospital staff. This course can be offered only a few times, and applications will be considered from those hospitals engaged in developing educational programs. Dr. J. P. Peters and Staff. $300 for 8 sessions. Those hospitals wishing to take advantage of this opportunity should direct inquiries to the Assistant Dean in charge of Postgraduate Medical Education.

MEDICINE 203—NUTRITION AND DIET

A course covering basic principles of nutrition, problems of malnutrition in various clinical conditions, nutritional appraisal, and dietetics in medical practice will be offered beginning in January 1949. Further details of this course, which will consist of 12 periods of 2 hours each once a week, will be available at a later date.

MEDICINE 204—FUNDAMENTALS OF ENDOCRINOLOGY

A course reviewing in a systematic manner the pres knowledge and new developments in endocrinology w be offered. This course will consist of 16 lectures of c and one half hours each, 2 lectures per session, once week for 8 weeks in the evening. Further details will available at a later date.

MEDICINE 205—INFECTIOUS DISEASES

A course reviewing the etiology, epidemiology, prev tion, diagnosis and treatment of infectious diseases co monly encountered in practice in New England will offered beginning in January, 1949. Further details of t course which will consist of 12 sessions, 2 hours each, or a week, will be available at a later date.

OBSTETRICS 200—OBSTETRICAL CONFERENCE

This course will cover important problems encounter in obstetrical practice. Attention will be given to roentg pelvimetry, bleeding, indications for induction of lab therapeutic abortion, toxemias, common ante partum co plications, the Rh factors, and to "natural childbirth." sessions of 2 hours each. Doctors H. Thoms, J. A. Fiori I. Friedman, F. W. Goodrich, Jr., C. E. Johnson, L. Musselman, C. H. Peckham, E. L. Stone, L. M. Stov Oct. 5—Dec. 7, 1948. Tuesdays 10-12 A. M. Room 30 FMB. Minimum enrollment 15; maximum 25. Fee $35.

PATHOLOGY 200

This is a course designed for practicing physicians a will review the present status of etiology, pathogenesis a life history of disease processes commonly encountered practice. The conferences will include material from t case records and necropsy service of the Grace-New Hav Community Hospital and will be supplemented by mater from the experimental laboratories of the Department Pathology. 11 sessions of 2 hours each. Doctors H. S. Greene, H. Bunting, A. A. Liebow, J. H. Milstone, L. Waters. Jan. 4—March 15, 1949. Tuesdays 10-12 A. M. B Minimum enrollment 20. Fee $45.

PEDIATRICS 200

This course will cover common problems in the care children. Attention will be given to infant feeding, diarrh and vomiting, blood diseases, heart diseases, allergy, chem therapy and antibiotics in pediatric practice, intraveno therapy, and growth and development. 12 sessions of 2 hou each. Doctors G. F. Powers, C. S. Amatruda, D. H. Cl ment, E. C. Curnen, D. C. Darrow, M. Y. Krosnick, P. Lurie, and R. Whittemore, Jan. 6—March 24, 1949. Thur days 10-12 A. M. 3108 LMP. Minimum enrollment 1 maximum 15. Fee $60.

PEDIATRICS 201—PEDIATRIC NEUROLOGY

A course is planned for the Spring of 1949 at the Sout bury State Training School for physicians interested the neurological problems of children. Attention will b given to the pathogenesis, clinical aspects, prognosis a management of such conditions as infantile cerebral pals congenital encephalopathy, early acquired diseases of t nervous system, mental deficiency, mongolism, cretinis

d congenital endocrinal dystrophies, convulsive disorders d prenatal infections. 16 hours in the Spring of 1949. nder the direction of Dr. H. Yannet. Further informan will be available later.

YCHIATRY 200—SECOND CONNECTICUT POSTGRADUATE MINAR IN NEUROPSYCHIATRY

See announcement on same page.

YCHIATRY 201—THEORY OF PSYCHOANALYSIS

This course is planned for early 1949 to consist of 14 tures in 7 weekly evening sessions. Further details will available later.

BLIC HEALTH 200—OCCUPATIONAL MEDICINE AND HYGIENE

To be announced.

RGERY 200—SURGICAL DIAGNOSIS

This course will review the methods and criteria of rgical diagnosis and their relative importance, indications r surgical treatment and results to be anticipated in contions commonly encountered in general practice. Followg a general presentation there will be case teaching, estions and answers. 12 sessions of 2 hours each. Doctors . W. Oughterson, N. Canfield, C. C. Clarke, C. L. Demg, M. S. Eveleth, W. J. German, G. E. Lindskog, E. J. ttenheimer, E. L. Stone, M. Taffel. Sept. 29—Dec. 15, 48. Wednesdays 9:45—11:45 A. M. Far. A. Minimum enllment 20. Fee $45.

RGERY 201—TRAUMATIC SURGERY

A course reviewing the traumatic surgical problems frenently encountered in practice. Attention will be given the practical management of wounds, shock, burns, and various regions such as the head, chest, abdomen and tremities. The use of chemotherapy, blood and blood rivatives, and anesthesia will be included. 12 sessions of hours each. Dr. A. W. Oughterson and others. Jan. 5—larch 23, 1949. Wednesdays 9:45—11:45 A. M. Far. A. linimum enrollment 20. Fee $45.

RGERY 203—EARLY DIAGNOSIS OF CANCER

This course is arranged to emphasize the early detection f cancer rather than a detailed differential diagnosis of ecific types. The subject will be covered by systems, and eatment will be considered from the standpoint of results ther than technique. The regular tumor conference to hich physicians are invited immediately precedes this lass, 1:30—2:30 P. M. 12 sessions of 2 hours each. Dr. S. . Harvey and others. March 22—June 7, 1949. Tuesdays :45—4:45 P. M. Far. A. Minimum enrollment 20; maximum o. Fee $45.

URGERY 204—ORTHOPEDICS

This course will cover common orthopedic conditions een by practicing physicians. Emphasis will be on non perative forms of treatment. Topics will include backache, ongenital deformities, bursitis and other affections of the oft tissues, arthritis, simple fractures, lesions of the shoulder, foot and knees, and affections of the epiphyses. 10 essions of 2 hours each. Doctors M. S. Eveleth, A. L. Bassin, W. S. Perham, D. S. O'Connor, A. D. Poverman. Oct. 8—Dec. 17, 1948 (except Nov. 26). Fridays 9:45—11:45 A. M. Far. A. Minimum enrollment 20; maximum 30. Fee $35.

THERAPEUTICS 200—MODERN DRUGS AND COMMON PROBLEMS IN THERAPY

This course is for practicing physicians and is concerned with common problems in therapeutics, with special reference to new forms of medicinal agents. The objective is to discuss typical approaches in treatment, with emphasis on contraindications and dangers. These will be discussed in seminars jointly by a pharmacologist and a clinical specialist in each of the various fields. Among the groups of drugs to be considered are antibiotics, antihistaminics, sulfonamides, and synthetic substitutes for morphine. 18 sessions of 2 hours each. Dr. W. T. Salter and Staff. Among the clinical specialists who will participate are Doctors E. M. Blake, S. C. Harvey, H. M. Marvin, and H. Thoms. Feb. 1 to May 31, 1949. Tuesdays 7 to 9 P. M. B203 SHM. Minimum enrollment 20; maximum 30. Fee $55.

The Second Connecticut Postgraduate Seminar of Neuropsychiatry

September 27, 1948—April 25, 1949

Sponsored by Joint Committee of the State Mental Hospitals and Department of Psychiatry and Mental Hygiene, Yale University School of Medicine.

EXECUTIVE COMMITTEE

Edgar C. Yerbury, M.D., Superintendent, Connecticut State Hospital, Middletown, Connecticut.

Philip J. Moorad, M.D., Representative of the Connecticut State Medical Society.

Frederick C. Redlich, M.D., Executive Officer, Department of Psychiatry and Mental Hygine, Yale University School of Medicine.

Clements C. Fry, M.D., Department of University Health, Yale University.

Paul I. Yakovlev, M.D., Director of Research and Training, Connecticut State Hospital, Middletown, Connecticut (Curricular Secretary of the Seminar.)

The program of the Seminar is designed for the medical personnel of the State psychiatric hospitals and institutions and the certain professional affiliates and graduate trainees of the departments of the School of Medicine. It is open to residents, house officers and interns of private and community hospitals and to physicians in private practice.

The Seminar will consist of a *general course* on basic and clinical neurology and clinical psychiatry, including a review of psychosomatic medicine. Three *special courses* described elsewhere in the Bulletin are related to the seminar: (1) Fundamentals of Endocrinology (Medicine 204), (2) Theory of Psychoanalysis (Psychiatry 201), (3) Pediatric Neurology (Pediatrics 201).

The *general course* will be given once a week on Mondays from 4 P. M. to 10 P. M. beginning September 27, 1948 and ending April 25, 1949, with a recess from December 7, 1948 to January 2, 1949. Each Monday session will consist of three one and one half hour lectures. A total of 84 lectures is scheduled for the entire course. The cur-

riculum of the *general course* will consist of three parts:

1. *Basic Neurology*—33 lectures at the Connecticut State Hospital, Middletown, Connecticut, September 27—December 6, 1948.

(a) Anatomy of the Nervous System—11 lectures.

(b) Physiology of the Nervous System—9 lectures.

(c) Neuropathology—9 lectures.

(d) Applied electrophysiology and electro-encephalography—4 lectures.

2. *Clinical Neurology*—27 lectures at Yale University School of Medicine, January 3—February 28, 1949.

(a) Semiotics of Diseases of the Nervous System—5 lectures.

(b) Topics of Clinical Neurology with Medical Implications—9 lectures.

(c) Topics of Clinical Neurology with Surgical Implications—8 lectures.

(d) Neuro-roentgenology—5 lectures.

3. *Psychosomatic Medicine and Clinical Psychiatry*—24 lectures at the Yale University School of Medicine, March 7—March 21, 1949, and at the Fairfield State Hospital, Newtown, Connecticut, March 28—April 25, 1949.

(a) Review of the Theory of Psychosomatic Disturbances of Bodily Functions—9 lectures.

(b) Clinical Psychology—7 lectures.

(c) Special Therapeutic Procedures in Psychiatry—8 lectures.

REGISTRATION AND FEES

Because of a financial subsidy by the Joint Committee of the State Mental Hospitals and the Department of Psychiatry and Mental Hygiene of the School of Medicine, the medical personnel of the state psychiatric hospitals and the professional affiliates and trainees of Yale University may attend the Seminar free of charge, but must formally enroll. Physicians who are not in the above category will be required to pay the Seminar fees: $75 for the entire course, $35 for Basic Neurology alone, $35 for Clinical Neurology alone, $35 for Psychosomatic Medicine and Clinical Psychiatry alone.

A detailed schedule of courses and lectures will be available for distribution on or before September 15, 1948. For a schedule or an application blank, write to the Assistant Dean in charge of Postgraduate Medical Education.

CONNECTICUT VA MEDICAL SOCIETY

The weekly medical conferences of the Connecticut Veterans Administration Medical Society will be resumed on September 9, 1948. Meetings will be held throughout the year on Thursdays at the Veterans Administration Building, 95 Pearl Street, at 8:30 A. M.

The September program follows:

September 9

1. Use of Nitrogen Mustards.
2. Cancer of Head and Neck by Dr. N. William Wawro, Clinical Assistant Surgeon, Hartford Hospital.

September 16

1. Cardio Pulmonic Disease by Dr. William Lah Assistant Chief of Medicine, Newington Veter Hospital.

September 23

1. Headache and Neuralgias about the Head by James C. Fox, Jr., Consulting Neurologist, Newing Veterans Hospital, Attending Neurologist, Hartf Hospital.

September 30

1. Chronic Liver Disease by Dr. Benjamin V. Wh Consulting Gastroenterologist, Newington Veter Hospital, Chief of Gastroenterology Clinic and Ass ant Attending Physician, Hartford Hospital.

HARTFORD HOSPITAL SATURDAY CLINIC PROGRAM OF GUEST SPEAKERS

September-October 1948, 11 A. M. to 12 Noon

Change to 1 hour later than formerly

September 18, 1948
Dr. Oliver Cope, (subject to be announced)

September 25, 1948
Dr. James R. Miller, "The World's Health Assembly Geneva 1948"

October 2, 1948
Film entitled "Post-Encephalitic Parkinsonism

October 9, 1948
Dr. Thomas J. Anglem (Mass. General Hospital, Por ville Hospital), "Career Surgery"

October 16, 1948
Dr. Chester Keefer, "Streptomycin"

October 23, 1948
Dr. Paul Swett, "Rheumatism"

October 30, 1948
Clinical Pathological Conference, Dr. Averill Liebow a Dr. John C. Leonard

N. E. INDUSTRIAL PHYSICIANS & SURGEON

The next meeting of the New England Conference Industrial Physicians and Surgeons will be September 1948, at the Copley Plaza Hotel in Boston.

FALL POSTGRADUATE COURSES AMERICA COLLEGE OF CHEST PHYSICIANS

The Council on Postgraduate Medical Education of t American College of Chest Physicians is sponsoring 3 po graduate courses in the latest developments in the special of Diseases of the Chest. Each of the courses will be one week's duration and are open to all physicians. Tuiti fee is $50.00 for each course, and registration is limit to fifty physicians for the courses being presented Chicago and New York City. Reservations will be accept in the order received.

San Francisco, California, September 13 through 17, 19. In cooperation with the University of California Medic School and Stanford University School of Medicine. F

ormation please write to Stacy R. Mettier, M.D., Head Postgraduate Instruction, Medical Extension, University California, San Francisco, California.

icago, Illinois, September 20 through 25, 1948.

Third Annual Postgraduate Course presenting the recent velopments in all aspects of diagnosis and treatment of seases of the Chest. Course to be held at the Hotel evens, Chicago.

ew York City, November 8 through 12, 1948.

First Annual Postgraduate Course presenting the newer pects of Diseases of the Chest. Course to be held at the otel New Yorker, New York City.

Applications for the courses to be given in Chicago and ew York City should be made through the Executive fices, American College of Chest Physicians, 500 North arborn Street, Chicago 10, Illinois.

EDICAL EDITORS AND WRITERS MEET AT SPRINGFIELD, ILL., SEPTEMBER 29

The fifth annual meeting, Mississippi Valley Medical itors' Association will be held at the Hotel Abraham ncoln, Springfield, Ill., September 29. This will probably the last meeting under the above title as the Associan's purpose will be enlarged and its constitution revised Springfield. Dr. Vincent T. Williams, President, of Kan City, Mo., Editor, Jackson County Medical Society eekly Bulletin, will preside. In the afternoon, Dr. Morris hbein, Editor, Journal American Medical Association, ll give a course in medical writing. There will be a felvship hour, dinner and speakers in the evening, including . Fishbein of Chicago and Dr. Waltman Walters of chester, Minn., Editor-in-Chief of Archives of Surgery d the Lewis-Walters' Practice of Surgery.

The meeting will be held during the thirteenth annual nvention of the Mississippi Valley Medical Society. All ical physicians and those interested in medical writing e cordially invited. Non members will be charged a small for the afternoon course in medical writing; there is registration fee for the evening session. Write Harold anberg, M.D., Secretary, W.C.U. Building, Quincy, nois, for a complete program.

XAMINATION FOR REGULAR CORPS, USPHS

A competitive examination for appointment in the Regu Corps of the United States Public Health Service in the ade of assistant surgeon (first lieutenant) and senior istant surgeon (captain) will be held in October. The itten examination will be conducted October 4, 5, and at places convenient to the candidates. The oral examation will be held at various points throughout the untry.

All applicants must be at least 21 years of age and citizens the United States, must present a diploma of graduation om a recognized medical school and satisfactorily pass physical examination performed by Public Health Service ficers.

Physicians beginning internship on July 1, 1948, will be mitted to the examination. Successful candidates will be placed on active duty in the Regular Corps upon completion of internship on July 1, 1949.

Applicants for the grade of assistant surgeon must have had a least 7 years of educational and professional training or experience, exclusive of high school. Applicants for the grade of senior assistant surgeon must have had at least 10 years of educational and professional training or experience, exclusive of high school.

Entrance pay for an assistant surgeon with dependents is $5,011 a year and for senior assistant surgeon with dependents $5,551 a year. This includes the additional pay of $1,200 for medical officers, as well as subsistence and rental allowance. Provisions are made for promotions at regular intervals up to and including the grade of senior surgeon (lieutenant colonel) and for selection for promotion to grade of medical director (colonel) at $9,751 a year. Retirement is authorized at either completion of 30 years' service or at the age of 64. Full medical care including disability retirement at three-fourths pay is provided.

Application forms may be obtained from Public Health Service Hospitals, District Officer or by writing to the Surgeon General, United States Public Health Service, Washington 25, D. C.

THE NASHVILLE POSTGRADUATE MEDICAL ASSEMBLY

October 6-7, 1948

Sponsored by the Nashville Academy of Medicine. Principal meetings at Hermitage Hotel. Luncheon served daily at Andrew Jackson.

THE AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

The Sixth Annual Meeting of The American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery will be held at The Palmer House, Chicago, on Saturday, October 9. Complete programs may be obtained by writing to the Secretary, Dr. Norman N. Smith, 291 Whitney Avenue, New Haven 11.

Recent action by the Society provides for associate and corresponding membership in addition to full fellowship. Complete details are available through the Secretary.

CORNELL UNIVERSITY MEDICAL COLLEGE GRADUATE INSTRUCTION IN INTERNAL MEDICINE

Cornell University Medical College is now offering Graduate Instruction in Internal Medicine and Neurology. The teaching facilities of the Second (Cornell) Medical Division, Bellevue Hospital, New York City, comprising one hundred and forty-five beds, are devoted exclusively to this work. The Instructors are members of the Faculty of Cornell University Medical College.

The course is designed to give practical instruction in the subjects of Internal Medicine, Neurology, and Pathological Physiology. The work consists of daily bedside

study of patients on the medical and neurological wards. Each physician is assigned a series of patients and cooperates with the Resident and Attending staff in their care. A limited number of men may obtain special training in cardiology, hematology, diabetes, endocrinology and gastro intestinal diseases in the special clinics of the Out Patient Department. All students receive practical instruction in electrocardiography.

The bedside teaching is supplemented by conferences each week to cover morbid anatomy, clinical medicine, gastro enterology, pulmonary disease and the surgical aspects of medical problems.

The teaching program is a continuous one and physicians are admitted on the first of each month as vacancies occur. For any one individual, the course is of either three months or six months duration. The three months course may include six weeks of neurology and six weeks of medicine or may be limited entirely to medicine. The maximum number of physicians registered in the course at any one time will be limited to twenty-five.

An examination is offered by the Department of Medicine, Cornell University Medical College, at the end of the course. Successful completion of this examination and satisfactory ratings by individual tutors will be required of those who desire credit in partial fulfillment of the requirements of the American Board of Internal Medicine.

REQUIREMENTS FOR ADMISSION

Each applicant is required to submit a transcript of medical school record and information about hospital training and military service.

Inquiries and applications should be addressed to Dr. John E. Deitrick, Director, Second (Cornell) Medical Division, Bellevue Hospital, First Avenue and Twenty-sixth Street, New York 16, N. Y.

FEES

Tuition for the six months course will be $300. This course of instruction is within the provisions of Public Law 346, the so-called "G.I. Bill of Rights." Tuition for the three months course will be $150.

THE KELLOGG FOUNDATION

The initiation of this course of instruction utilizing the Second (Cornell) Medical Division, Bellevue Hospital, has been made possible through a generous grant of the W. K. Kellogg Foundation.

OTHER INSTRUCTION

Inquiries concerning other fields of instruction should be directed to the Office of the Dean, Cornell University Medical College, 1300 York Avenue, New York 21, N. Y.

NOMINATIONS FOR SCHOLARS IN MEDICAL SCIENCE

Medical schools in the United States and Canada are invited by the John and Mary R. Markle Foundation to make nominations for the second group of Scholars in Medical Science on or before December 1, 1948. Each school, through the dean, may nominate one candidate. No nominations from individuals will be considered.

The program is designed to aid promising young men and women planning careers in academic medicine, who have not yet made their reputations. They should have completed the usual fellowship training in some area of science related to medicine and should hold, or expect to hold, in the academic year 1949-1950 a full time faculty appointment on the staff of a medical school.

Grants of $25,000, payable at the rate of $5,000 annually will be made to the schools over a five year period for the support of each Scholar finally selected, his research or both.

The number of Scholars to be appointed in 1949 has not yet been determined. Sixteen were chosen in 1948. A new booklet describing the plan is available on request from the Foundation, 14 Wall Street, New York 5, N. Y.

MEDICAL OFFICER EXAMINATION ANNOUNCED

The U. S. Civil Service Commission has announced an examination for filling Medical Officer (Rotating Intern and Psychiatric Resident) positions in St. Elizabeth's Hospital, Washington, D. C.

Medical Officers (Rotating Intern) are paid $2,200 for the first year and $2,400 for the second year. Medical Officer (Psychiatric Resident) are paid from $2,400 to $4,100 a year depending upon the amount of approved postgraduate training the applicant has completed. Appointments are open for July 1, 1949. Internships consist of two years of rotating service, and Psychiatric Residencies consist of one to three years in psychiatry. To qualify for internships applicants must be third or fourth year students in an approved Medical School; however, they may not enter on duty until they have successfully completed the full course of study. Applicants for Psychiatric Residencies must be graduates of an approved medical school, with the degree of doctor of medicine, and, in addition, they must have completed an approved internship or must now be serving such an internship. No written test is required for the Medical Officer positions. Details about the requirements are given in the examination announcement.

Interested persons may secure information and application forms from the U. S. Civil Service Commission, Washington 25, D. C., from most first- and second-class post offices, and from Civil Service regional offices. Applications will be accepted until further notice in the Commission's Washington office.

Boost Hygeia Subscription Prices

The AMA Board of Trustees has authorized an increase of subscription prices for *Hygeia*, the health magazine of the AMA, as follows: single copy from 25 to 35 cents; one year from $2.50 to $3.00; two years from $4 to $5 and three years from $6 to $6.50. The new prices, occasioned by the increase in cost of material and labor, will go into effect on November 1.

FOR THE BUSY PHYSICIAN



The Journal brings you important news of national and state affairs. Our advertisers, in a large measure, make this possible.

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Take a moment to drop a penny postal to one of the advertisers in this issue. Ask for samples and literature. Both of us will profit. You will learn more about an AMA accepted product, and we will demonstrate to our advertiser that use of the Connecticut State Medical Journal is a valuable advertising contact.

THE CONNECTICUT STATE MEDICAL JOURNAL

OUR NEIGHBORS

Maine

Forrest B. Ames of Bangor assumed his duties as president of the Maine Medical Association at the close of the annual session on June 22. The new president-elect is Ralph A. Goodwin of Auburn.

Massachusetts

The new president of the Massachusetts Medical Society is Daniel B. Reardon of Quincy. Arthur W. Allen of Boston is president-elect.

New York

The Medical Society of the County of Westchester, New York, has voted a special assessment of $12 per member to meet the cost of a war memorial. This memorial will provide an education fund for the 58 children of physicians from Westchester County who died in service. The wording of the plan is as follows:

"No contribution to any of these children until they attain the age of 17 years or beginning upon completion of their secondary school education (high school) whichever is later, and thereafter each year a contribution of $600 per annum if they pursue a collegiate and/or professional postgraduate course up to the age of 25 years if they remain unmarried. The estimated cost of this plan would be $224,000."

Rhode Island

The Rhode Island Medical Society on June 15 suffered the loss of one of its outstanding members, Guy William Wells. Before and after World War II Dr. Wells was the member of the AMA House of Delegates from Rhode Island. His service to his country in the recent war was outstanding as Commanding Officer of the 52nd Station Hospital, first in North Africa, then in Italy.

Vermont

The Vermont State Medical Society is represented in the AMA House of Delegates by the youngest member in that House, aged 37 years.

The Vermont Cancer Society, Inc., was organized on April 8 under the sponsorship of the State Medical Society.

NEWS
from County Associations

Fairfield

Theron Robert Bradley, one of Norwalk's leadin physicians during the past 35 years, died at his sum mer home in Monticello, N. Y. on July 7. Only few weeks before his death Dr. Bradley had been patient in the Norwalk Hospital.

George G. Fawcett has resigned as chief of th Norwalk Hospital medical staff. This action follow more than 30 years of active practice and wa necessitated by ill health.

Aaron Billings Gates, a practising physician o Greenwich for the past 35 years, died suddenly a his home on July 9. Dr. Gates specialized in anes thesia and served as head of the department o anesthesia at the Greenwich Hospital from 1922 t 1946.

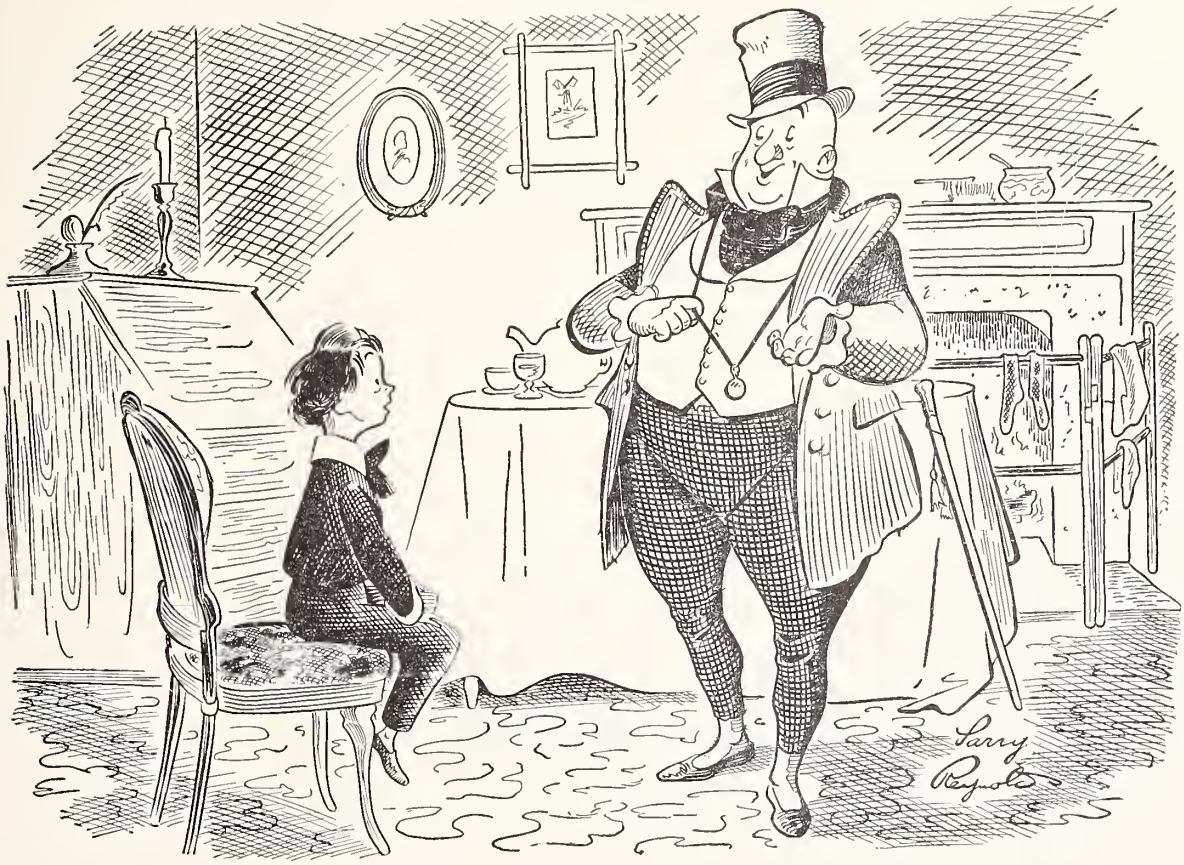
Dr. Charles S. Knapp has been elected chairma of the Greenwich Board of Health.

Hartford

The May issue of *The Modern Hospital* feature the new Hartford Hospital. Articles presenting th various phases of hospital construction and manage ment are contributed by the director, the enginee the business manager, the director of educatio various chairmen of staff committees and the archi tect. The plans of the different floors are included a well as a typical floor plan and story on the nev office building now under construction.

Charles C. Montano, a member of the staff of St Francis Hospital, Hartford, died suddenly at hi home in West Hartford July 14. Dr. Montano wa 38 years old and had graduated from Tufts Medica School in 1935 magna cum laude.

Benedict N. Whipple of Bristol died suddenly o a heart attack August 4 while playing golf at Chip panee Country Club. He had practised in Bristo since 1908, confining his practice of late years chief ly to surgery. Ben Whipple was very popular i Bristol and was a valued member of his county an state medical organizations.



Mr. Micawber was only half-right!

MR. MICAWBER'S financial advice to young David Copperfield is justly famous.

Translated into United States currency, it runs something like this:

> *"Annual income, two thousand dollars; annual expenditure, nineteen hundred and ninety-nine dollars; result, happiness. Annual income, two thousand dollars; annual expenditure, two thousand and one dollars; result, misery."*

But Mr. Micawber was only half-right!

Simply *not* spending more than you make isn't enough. Every family must have a cushion of savings to fall back on... and to provide for their future security.

U. S. Savings Bonds offer one of the best ways imaginable to build savings.

Two convenient, automatic plans make the systematic purchase of Savings Bonds both sure and trouble-free:

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Each helps you build a nest egg of absolutely safe, 100% government-backed U. S. Savings Bonds. And these bonds make more money for you while you save. For after only ten years, they pay you back $400 for every $300 you put in them.

Join the Plan *you're* eligible for today! As Mr. Micawber would say: "Result, security!"

AUTOMATIC SAVING IS SURE SAVING - U.S. SAVINGS BONDS

Contributed by this magazine in co-operation with the Magazine Publishers of America as a public service.

U.S. SECURITY LOAN

Litchfield

Charlotte Hungerford Hospital in Torrington has appointed as resident physician, Juan Pella, a graduate of the University of Havana, Cuba. Dr. Pella served his internship at Meriden Hospital.

New Haven

Eugene M. Blake of New Haven, clinical professor of ophthalmology at Yale, has been appointed a director of the National Society for the Prevention of Blindness and also a member of the Society's executive committee.

James Durkin has been appointed anesthesiologist at Grace Hospital to succeed Frank Herrick who is now chief anesthetist at Bennington Hospital, Bennington, Vermont.

The surgical residency of the Waterbury Hospital has been approved by the American College of Surgeons. The residency in urology and x-ray were approved last year.

Robert Bonner, Jr., has returned to Waterbury and resumed his practice in general surgery.

Ralph Gancher has opened an office in Waterbury for the practice of internal medicine.

Miss Ida Meier, formerly of the Backus Hospital in Norwich, Connecticut, will assume her duties as superintendent of the School of Nursing at the Waterbury Hospital in October.

New London

John Clifton Taylor, one of the oldest eye, ear, nose and throat specialists, died at the Lawrence Memorial Hospital on July 14. Previously practising in Scotland and South Manchester, Connecticut, Dr. Taylor had practised in New London since 1899.

Tolland

Thomas Francis O'Loughlin, dean of the Rockville physicians, died at his home on August 8 at the age of 75. Dr. O'Loughlin had practised in Rockville for 52 years. He was the first exalted ruler of the Rockville Lodge of Elks and was active in various community projects.

News from Yale University School of Medicine

Two Yale School of Medicine departments will work together to establish in September a long range training program for cancer control officers in the nation.

Dr. Ira V. Hiscock, chairman of the Yale Department of Public Health, announced that his organization will work with Dr. Samuel C. Harvey, director of the Section on Oncology of the Department of Surgery, to provide a one-year course for medical and other personnel who will specialize in the administration of programs caring for those afflicted by cancer.

This extends Yale's work in cancer research and therapy to still another field and augments the already important activities of the School of Medicine in cancer.

To head the new section on cancer control, the University has appointed Dr. Edward M. Cohart, formerly regional cancer consultant of the U. S. Public Health Service, as associate professor of Public Health.

Establishment of the section has been made possible by a grant of $24,000 from the U. S. Public Health Service National Cancer Institute.

"Yale has developed this program in recognition of the need for administrators of cancer programs in official and voluntary health agencies," said Dr. Hiscock, "as well as for statisticians, epidemiologists, health educators and public health nurses who are trained for cancer work."

Those who will be eligible for instruction at Yale include three classes of students, as follows:

1. Physicians who have had at least two years in medical practice or possess comparable experience.

2. Graduate nurses or individuals who hold a bachelor's degree who possess at least three years of experience in medical or dental care or public health work.

3. Special students who are not candidates for a degree, but who possess an appropriate background of training and experience, may be admitted to the courses in cancer control.

Experience is the Best Teacher

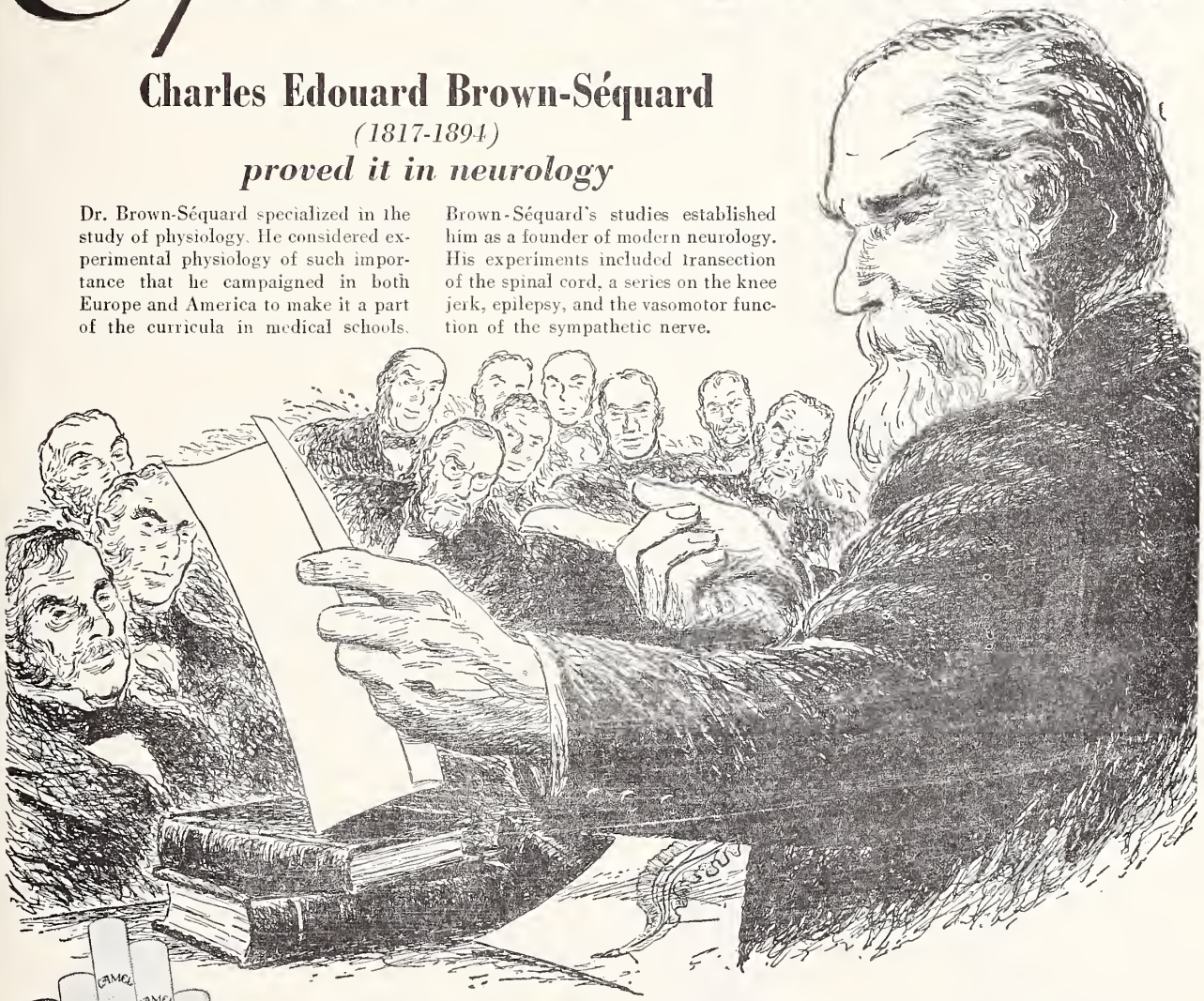
Charles Edouard Brown-Séquard

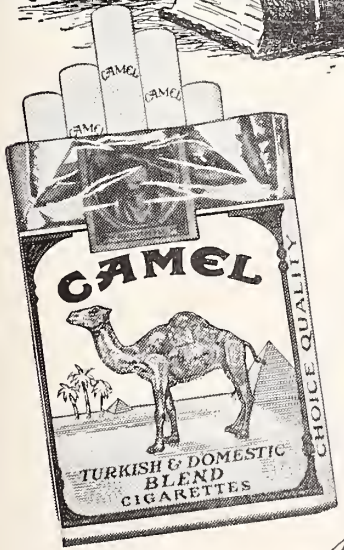
(1817-1894)

proved it in neurology

Dr. Brown-Séquard specialized in the study of physiology. He considered experimental physiology of such importance that he campaigned in both Europe and America to make it a part of the curricula in medical schools.

Brown-Séquard's studies established him as a founder of modern neurology. His experiments included transection of the spinal cord, a series on the knee jerk, epilepsy, and the vasomotor function of the sympathetic nerve.



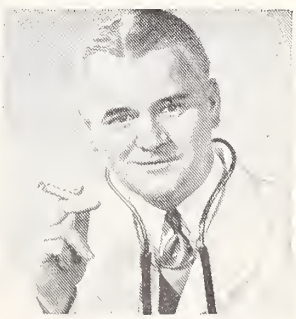


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Physicians who complete the full course are eligible for the degree of Master of Public Health or that of Doctor of Public Health in special cases. Other students may be candidates for the degree of Master of Public Health or Master or Science.

The Yale instruction will normally be one year in length. It includes basic courses in the principles of social science and organization of public health and medical care. It is arranged to supplement and not duplicate the previous training of an individual student.

In addition there will be specialized instruction in cancer control by means of lectures, conferences and seminars. At all times there will be cooperation with many agencies now engaged in the diagnosis, treatment, education and research into problems of cancer. This will include practical service in detection and diagnostic clinics.

Further information may be obtained from Dr. Edward M. Cohart, Cancer Control Section, Department of Public Health, Yale University School of Medicine, 310 Cedar Street, New Haven 11, Connecticut.

Society for Mental Hygiene Meets

A significant opportunity to reduce medical costs in hospitals lies in the field of psychiatry, Dr. Daniel Blain, United States Public Health Service, told members of the Connecticut Society for Mental Hygiene at their annual meeting June 4 at the New Haven Lawn Club.

Dr. Blain, also medical director of the American Psychiatric Association, said the costs of caring for mental patients is not evident in hospital budgets because it is impossible to estimate. The length of time required for mental patients to undergo adequate hospital treatment is so variable that statisticians cannot place it on an actuarial basis, he said.

Other speakers were Miss Frances Hartshorn, executive secretary of the Society; Dr. James M. Cunningham, Hartford, head of the Bureau of Mental Health; and Mrs. Malcolm Edgerton, Stamford.

Mrs. Anthony V. Lynch, Jr., of Greenwich, was elected new president of the Society; Harlan S. Don Carlos, Hartford, first vice-president; Dr. John L. Leonard, Hartford, second vice-president; John H. Jackson, New Haven, third vice-president; Mrs. Russell S. Bartlett, New Haven, secretary; and H. Wick Chambers, New Haven, treasurer.

NEW BOOKS IN REVIEW

WHAT IS PSYCHOANALYSIS? By Ernest Jones, M.D. *New York: International Universities Press.* 1948. 121 pp. $2.

Reviewed by Daniel P. Griffin

In this little book (121 pages) one of Freud's earliest and most prolific disciples presents the outline of this subject in a concise but informative fashion. There is little new in this offering and one is scarcely startled to learn (in the addendum) that twenty years had elapsed "since this book was first drafted." Yet the author finds on re-reading it "little that needs changing."

It consists of a number of short chapters which review the history of psychoanalysis, describe its content and explain its application to a wide variety of other subjects—medicine, education, anthropology, sociology and politics, criminology and law, art and literature, mythology and, of course, religion.

There are passages which the reader, who is unschooled in psychoanalytic theory will have difficulty in digesting. For instances, pages 44-45: "According to psychoanalysis the sexual instinct is a complicated one. It is made up of various components that have to fuse into an entity, and often fail in doing so. It has to undergo a rather elaborate course of development during which various difficulties may arise, errors in development, arrest at certain stages ('fixations'), and so on. Most remarkable of all is the fact that this development has to be passed through twice over, a feature apparently peculiar to man. The two periods of life at which this happens are in early childhood, below the age of five, and in the years following puberty. In the interval (the 'latency period') there is no progress in this development. The relationship between the two stages of development is highly interesting. Naturally they are not identical; the physical and mental differences between the child and the adult make this impossible. Nor is the development of the individual in general a simple repetition of the evolution of the race. But in both cases there is a considerable parallelism and the second development is very extensively determined by the nature of the first. The sexual development after puberty, for instance, assumes a multitude of forms, no two individuals being exactly alike in this respect as in any other, but the main lines on which it takes place, and often astonishing details, are already laid down in the first, childhood, phase. This is the reason why it is impossible either to understand or to remedy any error in the second, puberty, phase (together with the complicated consequences in neurotic disorders) without taking into due account the features in the first phase that determined those of the second one. All memory of that first phase is usually obliterated during the great wave of repression that accompanies this period of childhood; a part of it was, indeed, not conscious even at the time and can be recovered only by the psychoanalytic opening-up of the unconscious."

Again where difficulties with arithmetic are encountered by the child (page 76) psychoanalysis has an explanation which many will regard as unique: "Not merely can all

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arithmetic become 'difficult,' i.e., unconsciously prohibited, because of the unconscious association 'figures—counting on fingers—forbidden fingering,' but errors in computation can be traced to such factors as a queer half-conscious preference for certain figures and dislike of others, this, in turn, being due to what they may symbolize. It constantly happens during psychoanalysis that a faculty in which the patient believed he was deficient is simply released by overcoming the repressions unconsciously connected with it. Experiences such as this make one profoundly distrustful of the fashionable intelligence tests, for the simple reason that what is tested is never the same with different children. There is here a virgin field waiting for research." And again (page 78) "All children appear to pass through a stage of neurosis. Whether this is inevitable even with wiser upbringing, we do not know. Nor is it possible to predict the extent to which the child will spontaneously overcome the neurotic stage, or at what cost in later inhibition or predisposition to adult neurosis. The attempt has therefore been made to render the path of development more secure and less painful by analyzing the young child."

Again and again one is impressed with the really limitless scope of this comparatively new discipline. It is not surprising that it has remodeled psychology and reformed psychiatry and helped medicine to mature. It goes further (page 86): "The subject of health, for example, is surrounded by endless superstitions, fears, and taboos, which are by no means confined to the laity. Even in the most material field, that of economics, psychoanalysis has shown that it is rare for anyone to think freely and behave "normally" where money is concerned. One of the most surprising discoveries of psychoanalysis was that the idea of money is frequently a direct symbol of that of bodily dirt in the unconscious, and that the various complicated reactions to do with the latter idea constantly influence conscious judgments about money matters. To mention a single example, it was possible for a psychoanalyst to publish a prediction early in the first World War that after it had ended Great Britain would suffer acutely from unemployment because of an unduly hasty desire to return to the gold standard, a conclusion which even yet orthodox financiers refuse to perceive."

Under "Criminology and Law" (page 90-91) appears a statement startling to the uninitiated: "Intolerance of other people's wrong doing is a sure sign of an uneasy conscience, of the effort it is costing to suppress forbidden unconscious tendencies." Since I may be accused of lifting a sentence from its context, I quote the entire paragraph (page 90): "The fact that psychoanalysts of necessity adopt a deterministic attitude towards the question of moral responsibility has led some unthinking critics to attribute to them a total repudiation of punishment, a view which no analyst has, in fact, expressed. The whole question of punishment, both in this field and in that of education, is badly in need of psychological investigation, which is all that any analyst could ask for. It is at all events plain that in the present system of legal punishment the deterrent and reformatory motives commonly put forward often cover the deeper motive of retribution. If the former were the main one there would at once be instituted a serious scientific investigation into the preventive efficacy of the various forms of punishment. Similarly with the second ground adduced: s long as the problem is viewed as a moral and not psychological one, so long will the moral attitude of th law-maker and administrator mask the full psychologic motives. Psychoanalysis can reveal the nature of the fe that underlies the tendency to revenge, and this has muc more to do with people's apprehension at the immor tendencies in their own unconscious than with dread criminals. Intolerance of other people's wrongdoing is sure sign of an uneasy conscience, of the effort it is costin to suppress forbidden unconscious tendencies."

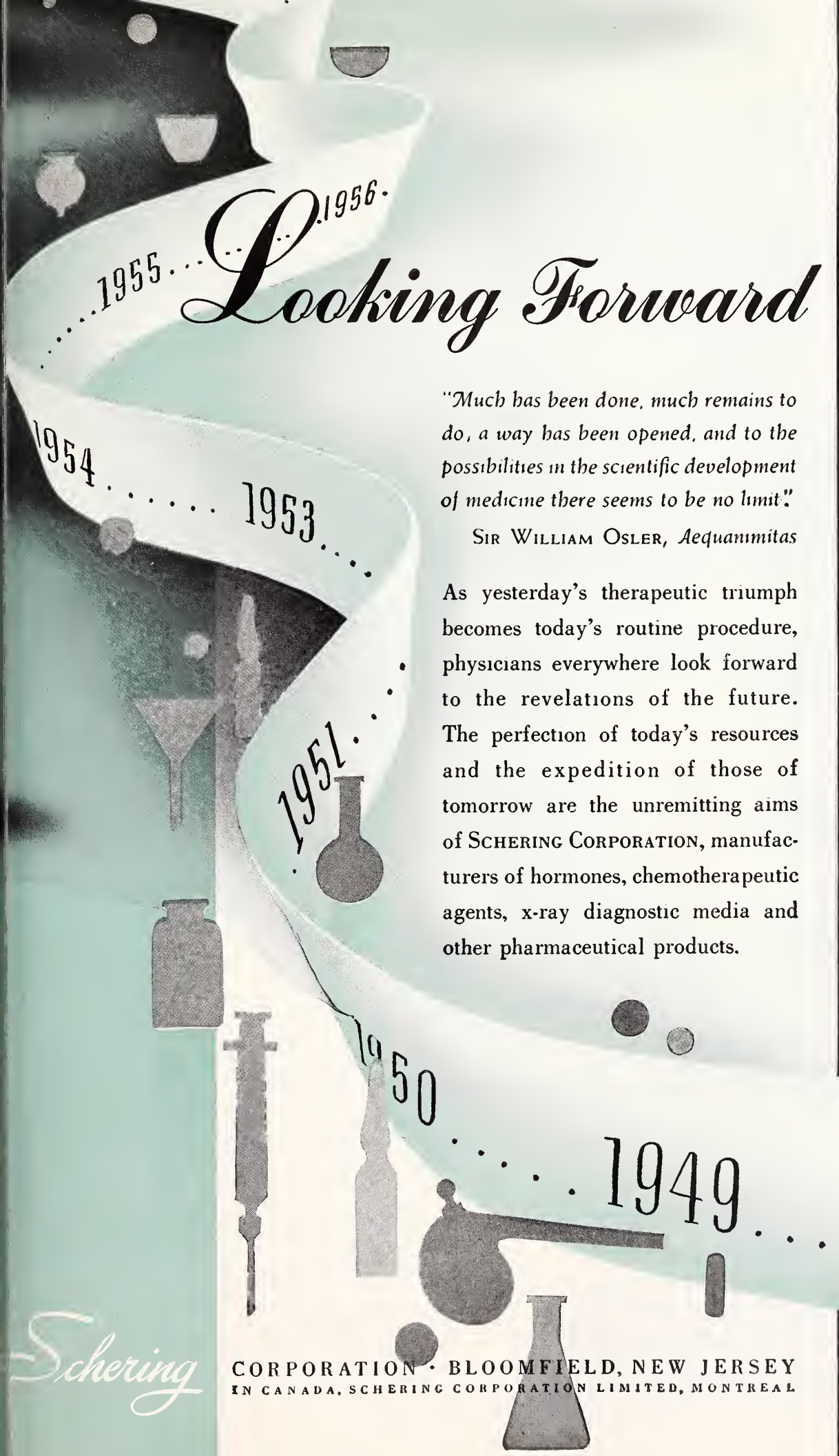
In "Conclusion" (page 107) Dr. Jones says: "The out standing conclusion to which we seem impelled is that th findings of psychoanalysis are either untrue or else they ar of momentous import. One thing is certain and that is th they are not half-true." Here the reviewer summons h remaining supply of ego to disagree. Although he unde went what he considers a successful analysis a number years ago he did not find it necessary to accept the doctrin in toto. Indeed, it is clearly possible to apply suitable po tions to it therapeutically without accepting some of i more fantastic formulations. For instance, Jones say (Addendum—page 116): "Freud also makes some valuabl suggestions concerning the distressing, and socially import ant, problem of anti Semitism. A number of other psycho analysts have also tackled this difficult topic and have show that its roots are far more complicated than is generall thought. It is, for instance, undoubtedly related to th "foreign body" fantasy of infants who have introjecte their parents, with the consequent reaction against th introjected person."

The non Freudian physician may find some passage indigestible. The book can hardly be blamed for this. Con sidering the complexity of the subject, the author has don an amazingly good job in presenting it in a simple, under standable and business like style. But if you don't lik psychoanalysis anyway, it is unlikely that this book wil convert you.

THE YEARBOOK OF PSYCHOANALYSIS. (Volum III, 1947.) *By Sandor Lorand*, M.D., New York, Managin Editor, and *Henry A. Bunker*, M.D., New York; *Ernes Jones*, M.D., London; *Bertram D. Lewin*, M.D., New York *C. P. Oberndorf*, M.D., New York, Editorial Board. *New York: International Universities Press.* 1948. 309 pp $7.50.

Reviewed by Richard Karpe

The third volume of this annual publication contain twenty well chosen papers which were published the pre vious year, and which deserve the attention of a wide reading public than just the subscribers of those periodical which publish them. With the great expansion of psycho analytic literature, such a yearbook is a very importan accomplishment. Such a selection may never be a perfec one, and it certainly does not mean that each of thos twenty papers is superior to any other psychoanalytic pape published that particular year. It does not mean that read ing one yearbook each year will provide all informatio about the psychoanalytic literature of that year, but i certainly is a good and important step in that direction. Fo



Looking Forward

"Much has been done, much remains to do, a way has been opened, and to the possibilities in the scientific development of medicine there seems to be no limit."

SIR WILLIAM OSLER, *Aequanimitas*

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the medical practitioner, who has only partial acquaintance with psychoanalysis, some of the papers will seem too technical and too involved. Some of the papers, however, deserve the interest of a wide audience, and do not preclude the elaborate training of the psychoanalyst for their understanding. Those readers, however, who have no knowledge of psychoanalysis and its literature, had better first try other more introductory books. A very interesting paper is the valedictory address of Ernest Jones, the founder of the British Institute of Psychoanalysis. It contains personal remarks and feelings as well as wisdom and objectivity. Very impressive is the remark of Freud, which he made to Jones shortly before his death: that in Freud's opinion the resistance of society against psychoanalysis, that means against the knowledge of the unconscious, had in no way diminished during the half century of his labors. It had only become slightly camouflaged. Jones tried to modify that, but has finally to agree with his teacher, and formulate it that way: that society feels much safer behind the new defenses, while on the other hand the life of the psychoanalyst has been rendered far more comfortable. He warns us against any illusion concerning the social influence of psychoanalysis. Of interest for us physicians in Connecticut are Jones' remarks about the relationship between psychoanalysis and medicine. He recommends a slow and indirect approach to the medical profession. Before any attempt to initiate the physicians into the content of the unconscious we should make them realize the existence of the problems themselves. He considers the neurosis-consciousness of the medical profession a first and essential step to an appreciation of the nature of unconscious activities.

Angel Garma, the pioneer of psychoanalysis in South America, summarizes the psychoanalytic knowledge about depressive and manic states in an instructive paper, "Melancholia and Depressions," and adds to this summary some contributions of his own to the genesis of depression. He assumes that hostile behaviour of the mother, and other important libidinous objects of childhood aroused aggressive feelings in the child. The child could not dare to give in too much to his aggressive tendencies because they created the danger that he may lose the mother who is so important to him, and upon whom he is so dependent. He fights his aggressive feelings by displacing them against himself, turning against himself all the accusations which were meant against his mother. He makes a martyr of himself. Garma formulates: "The melancholic considers himself a criminal for wishing to kill and destroy . . . The melancholic considers himself as insignificant on account of not having been well fed during infancy, or rather, on account of not having received, through food, and motherly love, the narcissistic satisfactions indispensable to the efficient development of a positive self esteem." (Page 106.) In the manic state, the patient succeeds to deny everything painful. Instead of accusing himself, he creates more or less fantastic situations which correct the earlier frustrating experience.

Another contribution to the genesis of depression is Edith Jacobson's paper on "The Affect of Disappointment on the Ego and Super-Ego Formation in Normal and Depressive Development." Her paper is mainly a clinical one. Not every disappointment is harmful. Increasing disappointments contribute to the gradual discovery of the realistic object-world: "Whether this process of disillusionment has a constructive or destructive affect on the development of the child's ego and his sense of reality depends less on the severity of the disappointment than on the stage at which they set in." Psychoanalysis, studying first the pathological conditions, has achieved a better understanding of normal developments. Jacobson's paper is an important continuation of that tendency. It gives us a better understanding of the normal development after it has gained insight into the pathological one. The author discusses the clinical case of Peggy, which she has used in an earlier paper. She investigates the role of the ego-development in the origin of depression. She considers the feelings of guilt, self-accusations and suicidal impulses a failure of the restitutive process, which is a function of the super-ego. She concludes her paper with a differentiation between the mature super-ego of the healthy person, and the super-ego of the depressive patient. The normal super-ego is flexible with regard to outside forces, but firm, not prone to sudden change of its functions. It does not interfere with creative activities and freedom of the ego. In the depressive patient the super-ego is rigid, it deteriorates quickly in each depressive period by way of giving up its constructive functions. Edith Jacobson does not draw in this paper any conclusions for the prophylaxis of depression, but her paper seems to be an important step toward such conclusions.

The two papers of the late Otto Fenichel show us his importance as an interpreter of Freud's teachings. Their topics are overlapping and they do not therefore show us

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he multitude of fields to which Fenichel contributed his original thinking. We look forward to the publication of his collected papers which will be edited by his widow, Dr. Hanna Heilborn Fenichel.

Oberndorf's paper on "Constant Elements in Psychotherapy" is a challenge to a greater scientific study and evaluation of the different efficient factors in psychotherapy. He discusses frankly not only successes but failures of the psychoanalytic therapy as well. His paper had some influence on the national project which will be undertaken by the American Psychoanalytic Association. The purpose of this national project will be just such a scientific study.

Easy reading is the contribution by S. Bernfeld of San Francisco: "An Unknown Autobiographical Fragment by Freud." He interprets a screen memory of Freud, which has not previously been translated, and deducts quite convincingly that the material published there is of an autobiographical nature.

Cultural topics are covered by the contributions of: Walter Bernard, Hans Sachs, Else Frankel Brunswick, R. Nevitt, Sanford, Fritz Wittels, Marie Bonaparte and W. S. Inman. Additional clinical contributions are the papers of William Menninger on "War Neuroses," Sandor Lorand on "Compulsion Neuroses," Stephen Schonberger on "Nightmares," S. M. Payne on "Psychoanalytic Technique," Bertram Lewin on "Sleep and Dreams," and E. D. Adrian on "The Mental and Physical Origin of Behaviour."

May I therefore conclude my review of Volume III with the review of the previous Yearbook by C. C. Burlingame: ". . . A particularly well chosen work, brought in coverage with timely emphasis for current problems of clinical and social psychiatry." For any one interested in the current psychoanalytical literature, this Yearbook is a must.

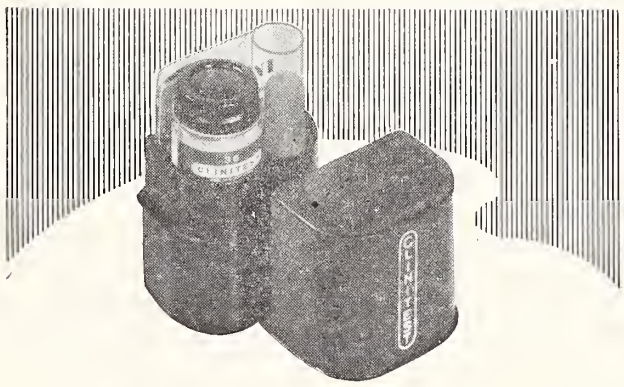
SURGICAL PATHOLOGY. (Sixth Edition.) *By William Boyd,* M.D., DIPL. PYSCH., M.R.C.P. ED., F.R.C.P. LOND., LL.D. SASK., M.D. OSLE, F.R.S.C., Professor of Pathology, The University of Toronto, Canada. *Philadelphia and London:* W. B. Saunders Company. 1947. 858 pp. with 530 illus. $10.

Reviewed by ROBERT TENNANT

The sixth edition of this well-known textbook of Surgical Pathology is written in the same sparkling style that has made all of this author's texts so popular among medical students and interns.

A new section on the physiology and pathology of congenital heart disease has been added because of the extension of surgery into this field since the last edition. The author has revised many chapters, adding newer information concerning pathogenesis of the diseases, as well as methods of diagnosis, the latter particularly in relation to neoplasms.

As a reference text the same criticism applies to this edition as has applied to those that have preceded it. The subjects generally are covered in a superficial fashion which frequently leads to statements that are inaccurate. References are not always chosen with sufficient critique. As an example, in the chapter on tumors of the testis it is stated that the Aschheim-Zondek test is frequently positive in testicular tumors and is of great value as a clinical test for malignancy. This statement is obviously based on the work



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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of Ferguson whose reference is cited. It is a well-known fact that subsequent investigations have been unable to substantiate the original claims of Ferguson.

In spite of such errors the text will undoubtedly continue its general popularity because of the fluent style of the author.

HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA, PART II. 1833-1944. *By the History Committee—John Benjamin Nichols,* Chairman; *William Johnston Mallory, Joseph Stiles Wall. Baltimore: Waverly Press, Inc.* 1947. 357 pp.

Reviewed by STANLEY B. WELD

This volume continues the story of the Medical Society of the District of Columbia published under date of September 1, 1909, the work chiefly of Dr. Daniel S. Lamb, and covering the years 1817-1909. In Part II is included an account of the formation of the Medical Association of the District of Columbia in 1833 and its existence to 1911 when the Society and the Association were amalgamated. The reasons for the existence of these two organizations will interest the student of medical history, particularly because of their different functions. The original Society was a licensing and scientific body, the Association, an economic and ethical one.

The authors of this volume describe the rugged and contentious egoism of the latter part of the 1820's resulting in a demoralization of the medical profession when personal jealousies, dissensions, and contentions were rife. This state of affairs in Washington resulted in the Medical Society forfeiting its Congressional charter and paved the way for the formation of the Medical Association which set up a uniform schedule of fees and a code of medical ethics and professional conduct. The most interesting chapter in the book is the one dealing with the history of the Medical Association from 1833-1911.

After the amalgamation of the Society and the Association the History gives a routine account of the affairs of the Society. The securing of funds for a home for the Society during the years of World War I and the completion of the building in 1921 testify to the vision and perseverance of a few leaders. The anti trust prosecution in the years 1938-1943 is recounted. The development of the Society's official publication, the early formation of the Woman's Auxiliary, the relationship with the medical schools of the District of Columbia are all described briefly. Fitting tribute is paid Dr. Coursen B. Conklin, secretary and treasurer from 1922 to 1938, and his successor Mr. Theodore Wiprud, the present encumbent of that office. the volume is well illustrated and contains several different lists of members.

The authors inform their readers that this volume, unlike Part I, does not include a presentation of biographical sketches of the membership. They apparently were appalled by the labor involved in such a task. It is a pity that no one could be found who had the interest and the time for the undertaking. As a result this volume lacks the sparkle and glamour of individual characters which not only lends interest to the reader but affords a valuable record for posterity. After the first few chapters the book becomes rather dull reading for the outsider. Then in the last chapter the authors combine a bit of philosophizing with apologies for their shortcomings. One paragraph worthy of note appears near the close.

"To live the life of an active and faithful physician is a noble achievement: subject and obedient at any and every moment to the imperative calls of duty, irrespective of personal comfort and convenience, and at the sacrifice of much home and social life; expending his energies and wasting himself in generous measure in arduous service to his patients; exposing himself without reserve to the risks to his health and to the personal peril of contagion and the violence of maniacs; imperturbably assuming responsibilities fraught with the gravest consequences; oblivious to the slanders of the malicious and the sneers of the detractors; sensing the thrill and satisfaction of ministering to the ailing and comforting the sorrowing, and of entering into the intimacies, the sorrows, and oftentimes the joys, of distressed hearts and homes; serving the needy gratuitously and generously; keeping abreast of medical progress; enjoying the well earned esteem, confidence, and affection of the community, of which he becomes an outstanding member: there are few avenues of life that are more worthwhile, or afford more satisfaction, or are more valuable to the world than the life work of the physician."

TWENTY-FIRST ANNIVERSARY YEAR OF HAROFE HAIVRI

The Hebrew Medical Journal, Volume I - 1948

The appearance of Volume I - 1948 of the *Harofe Haivri,* The Hebrew Medical Journal, inaugurates the 21st successful year of its publication under the editorship of Moses Einhorn, M.D. The Journal's contents are not confined to technical medical topics but is divided into several sections covering a variety of related subjects of interest to the medical profession.

The founders had faith in the vitality and growth of modern Hebrew and foresaw that a Hebrew medical publication would be of service to the future medical department of the Hebrew University and of great value in the development and advancement of Hebrew medical literature.

The section on Palestine and Health contains an article by A. Klopstock, M.D., which discusses the high incidence of amoebiasis in Palestine. Included also is the significant study of mental health in Palestine by A. H. Merzbach, M.D., and a survey of the present urological conditions in Palestine by W. Boss, M.D., Dr. M. Buchman describes the history of the Hot Springs of Tiberias and presents a full analysis of their therapeutic value.

In the section on Historical Medicine, Dr. M. Gelber reviews the contribution of the Jewish doctors in Poland during the eighteenth century. The section on Personalia contains a biographical sketch of Dr. I. Seth Hirsch, and his contributions to the field of radiology.

The original articles are summarized in English to make them available to those who are unable to read Hebrew. For further information, communicate with the editorial office of the *Hebrew Medical Journal,* 983 Park Avenue, New York 28, N. Y.

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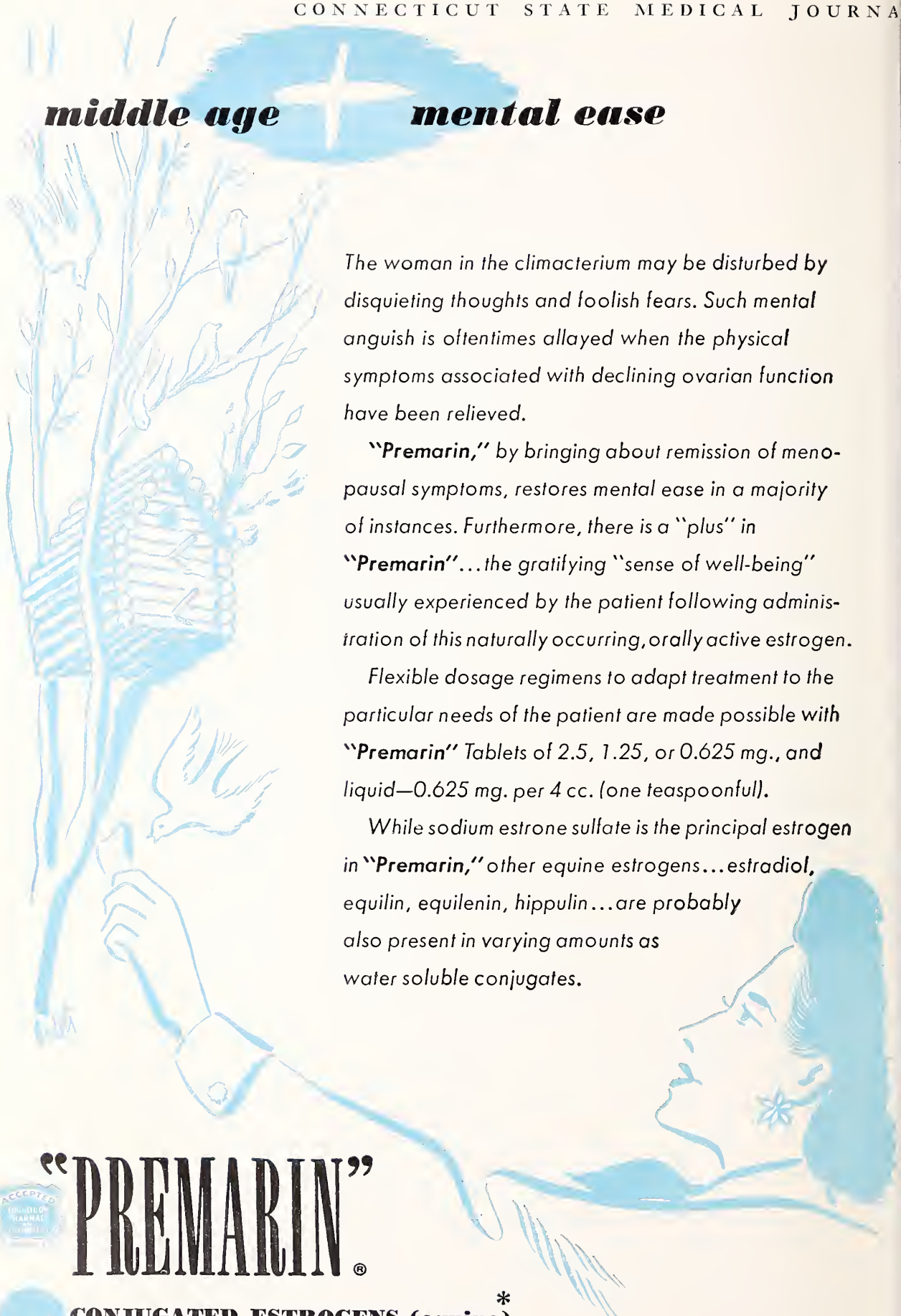
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STREPTOMYCIN: A REVIEW

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STREPTOMYCIN was first described by Schatz, Bugie and Waksman in 1944.[1] They suggested that this agent possessed antibiotic properties which might be effective in the treatment of disease caused by gram-negative as well as some gram-positive pathogens. It is produced by an actinomycete, described by Waksman, now known as *Streptomyces griseus*.

It is now well established as a useful and important antibiotic. It is somewhat more toxic than penicillin, but it is a natural complement to that drug and is of great value in treating many infections not effectively treated by either penicillin or the sulfonamides.

Streptomycin is the drug of choice in most gram-negative bacillary infections which are refractory to the sulfonamides, and in certain gram-positive coccus infections which are resistant to penicillin. In addition, it has proved to be a useful adjunct in the treatment of some types of tuberculosis, and more recently it has apparently been established as curative in granuloma inguinale.

ADMINISTRATION AND DISTRIBUTION

Streptomycin may be given intramuscularly, intravenously or subcutaneously. In general, the intramuscular route is the most satisfactory and is less likely to cause immediate systemic or localized reactions. Although this method of administration takes somewhat longer to produce maximum blood levels, detectable amounts are present in the blood for a longer time. Zintel et al[2] studied the blood levels of streptomycin following a single injection in 20 patients, and during the continuous administration of streptomycin in 19 patients. They found blood levels averaging 32.8 micrograms* per cubic centimeter 15 minutes following a single intravenous dose of 0.6 gms. After 6 hours the levels averaged 4.9 micrograms per cubic centimeter. They noted that maximum levels were obtained somewhat more slowly following subcutaneous or intramuscular injection and that they tended to be somewhat lower. The same authors found further, as did Anderson and Jewell,[3] that when streptomycin is given intramuscularly every three hours, additive effect is obtained and that approximately the same levels are obtained as when the same amount is given by intravenous drip. When 3.0 gms. daily were given by either method, the levels remained between 20 and 60 micrograms per cubic centimeter, and when 1.0 gm. was given the levels varied between 10 and 20 micrograms per cubic centimeter.[2] Buggs and associates[4] have pointed out that although the initial level is somewhat higher when the intravenous method is used, the levels are about the same after 2 hours. Rutstein et al[5] were able to demonstrate measurable amounts of the drug present 72 hours after the last of a series of intramuscular injections of 0.075 gms., while Elias and Durso[6] reported no trace 24 hours after the continuous administration of 4 gms. intravenously in one day. Numerous other authors are in agreement with the

*1 unit of streptomycin = 1 microgram.

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above findings. In our laboratory we have found evidence of streptomycin persisting in the serum for as long as 80 hours after the last intramuscular dose of 2.0 gms. was given. In a large number of routine determinations we have noted levels ranging from 4 to 64 micrograms per cubic centimeter when intramuscular streptomycin in dosage of 2.0 gms. daily was given, and between 4 and 32 micrograms per cubic centimeter when the dose was 1.0 gm. daily. All investigators[2,4,6,7,8,9] agree that streptomycin given orally is not absorbed in significant quantities from the normal intestinal tract and is excreted unchanged in the feces.

The distribution of systemically administered streptomycin is widespread and has been studied by many workers. The drug apparently penetrates into the pleural fluid rapidly as reported by Zintel et al,[2] and Adcock and Hettig.[10] Buggs et al[4] were able to find only traces in empyema cavities. The same authors have also demonstrated its presence in ascitic fluid and in the peritoneal fluid following rupture of a peptic ulcer. Zintel and associates[2] have found streptomycin in peritoneal fluid in amounts approximately equal to the blood levels.

Several authors mention the excretion of streptomycin in bile. Heilman et al[9] found it present in about twice the concentration found in the blood stream. In this connection the communication of Zaslow and associates[11] is of interest. They reported streptomycin in the bile only when the cystic duct was patent and when liver function was adequate. They failed to find it in the presence of obstructive jaundice with impairment of liver function. They were unable to demonstrate concentration of streptomycin by the gallbladder.

The presence of streptomycin has been demonstrated in the aqueous humor,[2,12] and in the cord blood, fetal blood, and amniotic fluid.[2,9,13] Reports differ as to the ability of streptomycin to pass the blood-brain barrier. Heilman et al[9] found none in the spinal fluid of 5 patients after repeated subcutaneous injections of 50,000 to 60,000 micrograms, or after a single subcutaneous dose of 200,000 micrograms. Similar results are reported by Buggs and associates.[4] On the other hand, Zintel et al[2] found small amounts appearing in the spinal fluid of healthy people following parenteral injections and a level of 25 micrograms per cubic centimeter in a single case of Hemophilus influenzae meningitis. Anderson and Jewell[3] found levels as high as 1.0 microgram per cubic centimeter in an individual suspected of having tuberculous meningitis. Significant level in the spinal fluid of 3 patients wit meningitis are also reported by Adcock and Het tig.[10] In our own experience we have observe traces of the drug in the spinal fluid irregularly i a patient with tuberculous meningitis who was re ceiving 2.0 gms. daily intramuscularly, without con comitant intrathecal treatment.

Adcock and Hettig[10] were able to study tissues o patients at autopsy who had been receiving strepto mycin before death. They found large amounts i the kidneys, smaller amounts in the lungs and hear muscle, and virtually none in the brain or liver.

In addition to its value when given intramuscu larly, the drug has proven useful when given intra thecally, intraperitoneally and by aerosol.[20] Al though small amounts of the drug appear irregularly in the spinal fluid, most investigators agree that i is necessary to inject additional amounts intrathe cally in the treatment of meningitis.[3,4,9,14,15,16,17,2] Daily injections of 50 mg. in 6 to 8 cubic centimeter of spinal fluid or sterile saline are usually wel tolerated for a few days, and are sufficient for mos infections.[8,14,18,19,22] In our experience it is fairly well retained and levels of from 4 to 16 microgram per cubic centimeter are usually present for 24 t 48 hours.

There are few reports on the use of the drug intrapleurally.[20,21] The report of the Council o Pharmacy and Chemistry of the American Medica Association[22] recommends solutions not stronge than 50 mg. per cubic centimeter be used for loca instillation. A review appearing in the Bulletin o the Army Medical Department[21] mentions the us of streptomycin intrapleurally in amounts up to 25 mg. per day for empyema.

Streptomycin aerosol may be used for gram-negative bacillary infections of the pulmonary tree Good results may be obtained with susceptible organisms in both acute and chronic cases, using 0.5 gm. daily in 5 to 8 divided doses.[20,23,24,25,2 Further work is needed to determine the ultimat course of chronic pulmonary infections following streptomycin treatment. It is not possible to obtai significant blood levels by aerosol administration.[9,10,26]

Streptomycin is excreted chiefly in the urine when administered parenterally. Only about 2 to 6 per cent is found in the stools.[2,3,4,5,6,9,27] Following a single intramuscular dose about 65 per cent is found to be excreted in 12 hours, and after 24 hours only traces are found in the urine. The drug is concentrated considerably in the kidney, a fact of import-

nce in the treatment of urinary tract infection. Depending upon the amounts given, and the urinary volume, levels as high as 4,000 micrograms per cubic centimeter have been reported.[28] It appears to be excreted by the glomeruli alone, the clearance having been measured as between 38 and 67 cubic centimeters of plasma.[10]

Clinical Applications

Streptomycin is most useful in the treatment of infections caused by gram-negative bacilli, and in certain infections caused by streptomycin sensitive gram-positive cocci which are resistant to penicillin.[20,22] Notable exceptions to this rule are generalized infections with the Salmonella group of organisms, including typhoid.[7,29,30,31] It is of limited usefulness in pertussis, and of no proven value in the treatment of fungus, virus and rickettsial diseases except granuloma inguinale.[20,22,62] Long lists of organisms with their sensitivities to streptomycin have been published. Unfortunately, this information is of little value in treating any individual case because of the variation of sensitivity within a given species. In practice it is advisable to have laboratory facilities to determine the in vitro sensitivity of organisms. In planning treatment, one should attempt to attain blood levels of at least 4 to 8 times that of the sensitivity of the organism involved.[20] In most acute infections it is important to give maximum doses (3.0 to 4.0 gms. daily for 7 to 10 days), rather than a small dose for a longer period. If the infection is still present after this period of time it will probably remain refractory. Longer periods of treatment are likely to cause toxic manifestations. It is not uncommon to find organisms which have become completely resistant to the drug, and in vitro tests may show increase in resistance from 10 to over 1,000-fold.[32,33,34] When this occurs, streptomycin should be abandoned. In chronic or less severe infections, doses of 2.0 gms. daily may be sufficient to control the disease.

Although the doses of streptomycin recommended above are admittedly higher than those used by some others, no serious toxic manifestation has been encountered in the eighteen months that this regimen has been in use at this hospital. The author feels that in those instances in which streptomycin is indicated, the risk of the development of serious toxic manifestations is much less than the risk of the disease. It should be emphasized that once bacterial resistance has developed, further use of streptomycin is useless. It is for this reason that the use of large initial doses is suggested. The drug is not without risk, however, and close observation for possible toxic manifestations should be maintained.

urinary tract infections

Streptomycin is effective in the treatment of gram-negative bacillary infections of the urinary tract when the organisms are not resistant to streptomycin, and when there is no anatomical obstruction to free urinary drainage.[34,35,36,37,38] Obstructions caused by strictures, stones and prostatic enlargement should be relieved either before, or within a day or two of, starting streptomycin. Foreign bodies such as catheters will militate against the effectiveness of the drug. Sensitivity to streptomycin of the infecting organism does not insure successful treatment, although the chances of cure are better than if the initial resistance is high.[34,36] In this hospital we have not yet seen a cure in an instance in which the initial resistance of the organism involved was greater than 40 micrograms per cubic centimeter. It is well established that streptomycin is more effective in an alkaline medium, and it is, therefore, of the greatest importance that a urinary pH of 8 be maintained during the entire period of treatment.[34,36,39,40] At this hospital the therapeutic program consists of first alkalinizing the urine, and then administering 4.0 gms. of streptomycin daily for 4 days by intermittent intramuscular injections. A longer period of treatment in the event of persistent bacilluria has not proven effective in our experience, and in every instance all organisms remaining have been completely resistant to streptomycin.

diseases of the respiratory tract

Streptomycin may be used both intramuscularly and by nebulization in treatment of gram-negative bacillary infections of the respiratory tract. The most frequently encountered organisms are those of the Klebsiella pneumoniae group (Friedlander's bacillus), and H. influenzae. In the treatment of acute pneumonitic infections the drug is best used intramuscularly in doses of 2.0 to 4.0 gms. daily for periods up to about 10 days. Although numerous successfully treated cases of Friedlander's pneumonia have been reported, the results are not uniformly good even though the organism is usually sensitive to the drug.[20,26,40,42] H. influenzae pneumonitis usually responds favorably and promptly.[20,23,24,26] We have recently seen a moderately severe case of pneumonitis from which this organism was recovered in large numbers. Following intramuscular injection of 2.0 gms. of streptomycin daily the sputum became free of H. influenzae in

24 hours with prompt clinical improvement. Subsequent cultures, however, revealed the presence of a pure culture of an organism of the coli-aerogenes group which was completely resistant to streptomycin in vitro. The patient recovered uneventfully in spite of the presence of this organism in the sputum.

In the treatment of bronchiectasis and other chronic pulmonary conditions, streptomycin aerosol is frequently effective in reducing the gram-negative flora and in diminishing the amount of sputum.[23,24,25,26] It may be given alone or in combination with penicillin, depending upon the cultural characteristics of the sputum. Unfortunately, the results are often only temporary and the organisms frequently return after treatment is stopped. In such instances it is often found that the organisms have acquired markedly increased resistance to the drug.

EMPYEMA

Too few cases have been reported to evaluate properly the effectiveness of streptomycin in treating empyema.[20,43,44] In general, intrapleural instillation of 100.0 mg. daily, in strengths of not more than 50.0 mg. per cubic centimeter, should be effective and safe.

SEPTICEMIA AND BACTERIAL ENDOCARDITIS

A trial of streptomycin is indicated in the treatment of all cases of bacteremia caused by gram-negative bacilli which show in vitro sensitivity to the drug. In addition, those cases caused by gram-positive cocci which are resistant to penicillin may prove to be susceptible to streptomycin.[20] The usual dose is 2.0 to 4.0 gms. daily, depending upon the resistance of the organism. The practice at this hospital has been to begin treatment with 4.0 gms. daily as soon as positive cultures are obtained. If the clinical response and the sensitivity of the organism are satisfactory, this dose can be decreased. So few cases of bacterial endocarditis have been treated with streptomycin that no definite regimen can be recommended.[45,46,47,48] In our own experience we have obtained one apparent cure in a case of endocarditis in which the organism was a gram-negative bacillus of the genus Bacteroides.[48] The patient received 4.0 gms. a day for 17 days and has now been well for 14 months.

In a second case of bacterial endocarditis, in which the infecting organism was a penicillin resistant alpha hemolytic streptococcus, streptomycin was instituted even though the resistance of the organism ranged between 50 and 100 micrograms per cubic centimeter.[48] For a week thereafter the temperatu was normal and blood cultures were negative. Th bacteremia returned, however, and it was found tha the resistance of the organism had increased to be tween 500 and 700 micrograms per cubic centimete The same organism was cultured from the stenose aortic valve at autopsy.

MENINGITIS

The drug has proven useful in the treatment o meningitis caused by susceptible gram-negative ba cilli including Salmonella,[20,51] coli-aerogenes,[20,44,4 and Hemophilus influenzae.[14,15,16,17,19,20,50] Resul in general have been good when the drug was give early. Alexander[16,17] states that streptomycin alon is sufficient in the treatment of moderately severe H influenzae meningitis of Type B, but that it shoul be combined with sulfadiazine with H. influenza infections other than Type B, and that in the mor severe infections specific serum should be added a well. Weinstein,[50] on the other hand, feels tha streptomycin alone is sufficient unless improvemer does not occur in from 72 to 96 hours. Maxima intramuscular doses should be used as well as intra thecal injections of 50.0 mg. daily in adults and fro 25.0 to 50.0 mg. daily in children.[33] In addition t the gram-negative bacillary infections, streptomy cin should be used in the treatment of streptomyci sensitive gram-positive coccus infections of th meninges when laboratory procedures indicate tha the organisms are resistant to penicillin. In a recen case of staphylococcus albus meningitis and bac teremia treated in this hospital, streptomycin pro duced a cure after the failure of penicillin and th sulfonamides. It was shown that the organism wa almost completely resistant to penicillin, but wa quite sensitive to streptomycin in vitro.

PERITONITIS

The value of streptomycin in peritonitis appear to be somewhat variable.[52,53] The Committee o Chemotherapeutics and Other Agents of the Na tional Research Council reports 53 cases of varie etiology.[20] There were 39 recoveries, 12 deaths an 2 cases unimproved. However, the effect of strepto mycin can only be inferred since more than hal of the patients received other forms of chemother apy as well. One might expect temporary benefit because of the general reduction of the bacteria flora of the colon when the drug is given by mouth Furthermore, it is known that parenterally admin istered streptomycin penetrates into the peritonea cavity in significant amounts.[2,4]

ULAREMIA

All reports attest to the value of streptomycin in l forms of tularemia.[20,54,55,56,57,58] The report of ıe Committee on Chemotherapeutics and Other .gents includes 67 cases of all types of tularemia ith recovery in 63. The average daily dose was nly 1.0 gm. per day for 7 days.

RUCELLOSIS

Early reports in the treatment of brucellosis were iscouraging.[59,60] It now appears to be effective in ıe treatment of the acute cases, particularly when ombined with sulfadiazine. Spink and associates[61] eport 35 cases of which 20 received sulfonamides, received streptomycin alone, and 9 received a ombination of streptomycin and sulfadiazine. Eight f the latter responded promptly and have remained ell. The course of treatment, as recommended by pink, consists of 0.5 gms. of streptomycin every 6 ours for 7 days, and sulfadiazine 4.0 gms. initially, ollowed by 1.0 gm. every 4 hours for 2 to 3 weeks. here is need for further investigation of this com-ination of drugs in the treatment of chronic rucellosis.

RANULOMA INGUINALE

In a recent communication by Kupperman, Greenblatt and Dienst,[62] the treatment of 48 cases f granuloma inguinale is reported with healing in ll, followed by relapse in only 3, of which 2 re-ponded to a second course of therapy.

UBERCULOSIS

It is not within the scope of this paper to discuss t length the use of streptomycin in the treatment f tuberculosis. At present it is best regarded as an djunct to previously established methods of treat-nent.

Its greatest effectiveness is seen in the treatment of draining sinuses and fistulae, and tracheobronchial disease.[22,63,64,66] In pulmonary tuberculosis, the best esponse is seen in exudative lesions.[22,63,64,66] Its alue in bone and joint, and in genito-urinary tuber-ulosis is questionable.[22,63,64,66] The effectiveness of streptomycin in the treatment of meningitis and miliary tuberculosis has been disappointing, but it is he only therapy available and some cures have been eported.[63,64,65,66]

Our own experience with miliary tuberculosis has been discouraging, in that 2 cases which were appar-ntly cured relapsed one month and two months, respectively, after cessation of therapy.

All investigators agree that the development of streptomycin resistant organisms occurs in the majority of instances with prolonged treatment.

TOPICAL USE

The topical use of streptomycin in the treatment of wounds infected with gram-negative bacilli is reported by several authors.[67,68,69,70] Strengths up to 200 micrograms per cubic centimeter have been found to be effective and safe.[69] It is probably best combined with either penicillin or sulfamylon.[69] It is not used topically for skin diseases at this hospital because of the frequency of skin sensitivity as reported by Strauss and Warring.[71]

TOXICITY

The toxicity of streptomycin is considerably greater than that of penicillin.[9,20,72,73,75] With the streptomycin first produced it was found that immediate reactions, including headache, flushing of the skin, fall in blood pressure, nausea and vomiting, and convulsions were not uncommon.[2,18,64,74] These so-called "histamine reactions" have been largely eliminated with the more highly purified products now available. There remain, however, a number of serious reactions apparently caused by the drug itself, since they occur when a highly purified product is used.[76] In general, these reactions are proportional to the total dose and occur chiefly during prolonged treatment with streptomycin. The largest collection of cases observed for toxicity reaction consists of 867 individuals studied by the Army, Navy and Veterans Administration and reported in a *Veterans Administration Technical Bulletin*. The figures given below are quoted from this report, unless otherwise indicated.

VESTIBULAR DYSFUNCTION

This occurred in 96 per cent of the patients in this series who were receiving 1.8 to 2.0 gms. daily, but in those receiving only 1.0 gm. daily, the incidence was sharply decreased. It usually developed during the fourth week of treatment. This condition is marked by varying degrees of vertigo, and usually goes on to complete loss of vestibular function, as measured by the caloric test, if treatment is continued. This loss is apparently permanent. With complete loss of vestibular function, however, the vertigo disappears and except for some unsteadiness in gait the patients are not uncomfortable and are able to compensate to a large degree, especially in the younger age group. This complication is not usually considered sufficiently grave to warrant dis-

continuance of treatment, since the danger of the disease in cases in which prolonged treatment is indicated is ordinarily of greater importance than the inconvenience of the loss of vestibular function. It should be remembered that with larger doses this complication may appear earlier. In this hospital one patient was found to have lost labyrinthine function after four days on 4.0 gms. daily.

DEAFNESS

This effect is much less common, appearing in 1.2 per cent of cases reported. Hearing tends to return toward normal if treatment is stopped before deafness is complete. The onset of hearing loss is rarely evident before the third week of treatment. Biweekly hearing tests, preferably with the audiometer, should be made after the third week. Progressive diminution in auditory acuity is considered sufficient cause for cessation of treatment unless the patient accepts the risk of permanent and total deafness.

EXFOLIATIVE DERMATITIS

This occurred in one per cent of the cases. Treatment should be stopped at once when this reaction appears. One such case observed at this hospital was first noted to have a maculo-papular rash and pruritus on the twenty-eighth day of treatment after receiving 64.6 gms. of streptomycin. The temperature rose to 104.0° and the percentage of eosinophils in the blood smear rapidly rose from 0 to 34 per cent. The patient was given benadryl, 50.0 mg. 4 times daily, when the rash was first noted, but the lesion rapidly became generalized and streptomycin was discontinued. By the third day the rash was purpuric in character, it did not blanch on pressure, and involved the entire body including the palms and soles, and the mucous membranes of the mouth. There was considerable edema of the face. The bleeding time, clotting time and prothrombin time were all within normal limits as was the platelet count. The capillary fragility test was strongly positive. The temperature remained elevated for 6 days, and as it subsided, a branny desquamation began which continued for one month. The patient ultimately recovered completely.

LEUKOPENIA

Diminution in the total white blood cell count with neutropenia was observed in 0.6 per cent of the cases. There was one case of granulocytopenia. The white count should be observed daily if this complication arises, and treatment stopped if the leukopenia is marked and progressive.

In addition to the above-named serious reactions there are other minor toxic manifestations which do not usually preclude continuation of treatment. They include transitory rashes, anorexia, mild fever, eosinophilia, myalgia, and the appearance of albumin and casts in the urine. The latter usually appear in acid urine, and for this reason it is well to keep the urine alkaline at all times. In 2.2 per cent of the combined Army, Navy and Veterans Administration series definite evidence of increasing renal dysfunction was found as measured by the BUN and clearance tests. In such cases treatment may have to be discontinued. This complication most frequently develops in previously damaged kidneys.

TOXIC REACTIONS ACCOMPANYING INTRATHECAL STREPTOMYCIN

Although various severe reactions have been reported in animals following intrathecal and intracisternal injection of streptomycin, there have been few reports of serious manifestations following the employment of this drug intrathecally in human beings. Most of these accompanied the use of the earlier, less pure product.[18,64,76] In our experience and that of others, the drug is well tolerated if given in amounts not exceeding 50.0 mg. per day, in well diluted doses. Farrington and associates[76] found that 100.0 mg. daily were not excessive. We have encountered one patient under treatment for tuberculous meningitis who complained of severe headache, neck pains, backache and pain down the posterior aspects of both legs following daily injections of 50.0 mg. of streptomycin. After a week's rest, however, treatment was resumed administering 50.0 mg. 3 times a week without discomfort to the patient. The author knows of one patient who received 800.0 mg. intrathecally in one dose without apparent ill effect. The appearance of increased numbers of lymphocytes has occurred in 3 patients studied at this hospital and has been reported by many others.[17,18,76]

SUMMARY

1. Streptomycin is the drug of choice in the treatment of infection caused by most gram-negative bacilli which do not respond to the sulfonamides, and by some streptomycin-sensitive gram-positive cocci.

2. It has proven to be a valuable adjunct in the treatment of certain types of tuberculosis.

3. Recent work suggests that it may be curative n granuloma inguinale.

4. Serious toxic effects, when they occur, usually ollow prolonged treatment. The most frequent erious reaction is loss of vestibular function. Others re exfoliative dermatitis, marked leukopenia, deafness and renal failure.

BIBLIOGRAPHY

. Schatz, Albert, Bugie, Elizabeth and Waksman, S. H.: Streptomycin, a substance exhibiting anti biotic activity gainst gram positive and gram negative bacteria. Proc. Soc. Exper. Biol. & Med., 55:66-69, 1944.

. Zintel, H. A., Flippin, H. F., Nichols, A. C., Wiley, M. M., and Rhoades, J. F.: Studies on streptomycin in nan. Am. J. M. Sc. 210:421-430, 1945.

. Anderson, D. G., and Jewell, M.: The absorption, excretion and toxicity of streptomycin in man. New England J. Med. 233:485-491, 1945.

. Buggs, C. M., Pilling, M. A., Bronstein, B., and Hirshfeld, J. M.: The absorption, distribution, and excretion of streptomycin in man. J. Clin. Investigation, 25:94-102, 1946.

. Rutstein, D. D., Stebbins, R. B., Cathcart, R. T., and Harvey, R. M.: The absorbtion and excretion of streptomycin in human chronic typhoid carriers. J. Clin. Investigation, 24:898-909, 1945.

. Elias, W. F., and Durso, J.: Blood, urine, and fecal levels of streptomycin in the treatment of human infections of E. typhosa. Science 101:589-591, 1945.

. Reiman, H. A., Elias, M. F., and Price, A. H.: Streptomycin for typhoid: pharmacologic study. J.A.M.A., 128: 175-180, 1945.

. Kornegay, G. B., Forgacs. J., and Henley, T. F.: Studies on streptomycin, II. Blood levels and urinary excretion in man and animals. J. Lab. & Clin. Med., 31:523-534, 1946.

. Heilman, D. H., Heilman, F. R., Hinshaw, H. C., Nichols, D. R., and Herrell, W. E.: Streptomycin: absorption, diffusion, excretion, and toxicity. Am. J. M. Sc., 210: 576-584, 1945.

. Adcock, J. D., and Hettig, R. A.: Absorption, distribution and excretion of streptomycin. Arch. Int. Med., 77: 179-195, 1946.

. Zaslow, J., Counseller, V. S., and Heilman, F. R.: The excretion and concentration of penicillin and streptomycin in the abnormal human biliary tract: preliminary report. Proc. Staff Meet., Mayo Clin., 21:94-96, 1946.

. Leopold, I. H., and Nichols, A.: Intraocular penetration of streptomycin following systemic and local administration. Arch. Ophth., 35:33-38, 1946.

. Woltz, J. H. E., and Wiley, M. M.: Transmission of streptomycin from maternal blood to the fetal circulation and the amniotic fluid. Proc. Soc. Exper. Biol. & Med., 60:106-107, 1945.

. Birmingham, J. R., Kaye, R., and Smith, M. H. D.: Streptomycin in the treatment of influenzal meningitis. J. Pediat., 29:1-13, 1946.

. Butler, L. J., Yaw, M. D., and Reinhart, J. B.: Meningitis due to Hemophilus influenzae: report of a case treated with sulfadiazine, streptomycin and anti-serum with recovery. North Carolina M. J. 7:8-12, 1946.

. Alexander, H. E.: Streptomycin in pediatrics. J. Pediatrics, 29:192-198, 1946.

. Alexander, H. E., Leidy, G., Rake, G., and Donovick, R.: Hemophilus influenzae meningitis treated with streptomycin. J.A.M.A. 132:434-440, 1946.

. Paine, T. F., Murray, R., Harris, H. W., and Finland, M.: Streptomycin in treatment of certain gram negative bacillus infections of central nervous system. Am. J. M. Sc., 213:676-685, 1947.

. Cairns, M., Duthrie, E. S., and Smith, H. V.: Intrathecal streptomycin in meningitis: clinical trial in tuberculous, coliform and other infections. Lancet, 2:153-155, 1946.

. Committee on Chemotherapeutics and Other Agents. National Research Council. Streptomycin in the treatment of infections; a report of 1000 cases. J.A.M.A., 132:4-11 and 70-77, 1946.

. Streptomycin, Status report on its therapeutic use. Bull. U. S. Army M. Dept., 6:565-570, 1946.

. Council on Pharmacy and Chemistry, American Medical Association. J.A.M.A., 135:839, 1947.

. Olsen, A. M.: Streptomycin aerosol in treatment of chronic bronchiectasis: preliminary report. Proc. Staff Meet., Mayo Clin., 21:53, 1946.

. Durant, T. M., Sokolchuk, H. J., Norris, C. M., and Brown, C. L.: Streptomycin therapy in Hemophilus influenzae pulmonary infections. J.A.M.A., 131:194-196, 1946.

. Zantiny, W. G., and Carlson, H. J.: Experiences with streptomycin: effectiveness in infections of infants and children. Clinics, 5:635-645, 1946.

. Harris, H. W., Murray, R., Paine, T. F., and Finland, M.: Streptomycin treatment of pulmonary infections: clinical and bacteriologic studies of six cases. New Eng. J. Med., 236:611-622, 1947.

. Robinson, H. J.: Streptomycin and streptothricin: the aborption, excretion, and chemotherapeutic properties. Ann. New York Acad. Sc., 48:119-142, 1947.

. Heilman, D. H.: Method for estimating concentration of streptomycin in body fluids. Proc. Staff Meet., Mayo Clinic. 20:146-150, 1945.

. Reiman, H. A., Price, A. H., and Elias, M. F., Streptomycin in the treatment of typhoid fever. Bull. New York Acad. Med., 21:433, 1945.

. Grossman, L. H., and Hunt, J. S.: Typhoid fever—a treatment failure with streptomycin. Am. Practitioner, 1: 45-46, 1946.

. Goldbloom, A. A., Dumonis, A. A., and Seidmon, E. E. P.: Streptomycin in typhoid fever; review of current literature and usage. New York State J. Med., 46:1936-1939, 1946.

. Miller, C. P., and Bohnoff, M.: Streptomycin resistance of gonococci and meningococci. J.A.M.A., 130:485-488, 1946.

. Alexander, H. E., and Leidy, G.: Influence of streptomycin on type B Hemophilus influenzae. Science, 104:101-102, 1946.

. Finland, M., Murray, R., Harris, H. M., Kilham, L., and Meads, M.: Development of streptomycin resistance during treatment. J.A.M.A., 132:16-21, 1946.

35. Jacobi, H. G.: Streptomycin in the treatment of a case of persistent urinary infection. New York State J. Med., 46:883-890, 1946.

36. Hewitt, W. L.: Treatment of urinary tract infections with streptomycin. Am. J. Med., 2:474-484, 1947.

37. Petroff, B. P., and Lukas, F. V.: Streptomycin in urinary tract infections. Ann. Surg., 123:808-818, 1946.

38. Herrold, R. D., Indications for anti biotics in urinary tract infections. Illinois M. J., 90:216-221, 1946.

39. Keefer, C. S., Weinstein, L., and Hewitt, W. L.: Clinical experience with streptomycin. M. Clin. North America, 985, (Sept.) 1946.

40. Nichols, D. R., and Herrell, W. E.: Streptomycin: its clinical uses and limitations. J.A.M.A., 132:200-206, 1946.

41. Bishop, C. A., and Rasmussen, R. F.: Klebsiella pneumoniae treated with streptomycin, J.A.M.A., 131:821-822, 1946.

42. Learner, N., and Minnick, W. R.: Friedlander's pneumonia treated with streptomycin: report of a case with prompt recovery. Ann. Int. Med., 25:516-520, 1946.

43. Bull. U. S. Army M. Dept. Streptomycin: status report on its therapeutic use. 6:565-570, 1946.

44. DeBakey, M. E., and Pulaski, E. J.: Analysis of experience in U. S. Army hospitals: preliminary report. Surgery, 20:749-760.

45. Hunter, T. H., and Duane, R. B., Jr.: Sub-acute bacterial endocarditis due to gram negative organisms. J.A.M.A., 132:209-211, 1946.

46. Priest, W. S., and McGee, C. J.: Streptomycin in treatment of sub-acute bacterial endocarditis: report of three cases. J.A.M.A., 132:124-126, 1946.

47. Hunter, T. H.: Use of streptomycin in the treatment of bacterial endocarditis. Am. J. Med., 2:436-442, 1947.

48. Cressy, N. L., Lahey, W. J., and Kunkel, P.: Streptomycin in the treatment of bacterial endocarditis: a report of two cases. To be published.

49. Alexander, A. J.: Meningitis due to Escherichia coli treated with streptomycin. J.A.M.A., 131:663-665, 1946.

50. Weinstein, L.: The treatment of meningitis due to Haemophilus influenzae with streptomycin: a report of nine cases. New England J. Med., 235:101-111, 1946.

51. Barnes, M.: Salmonella meningitis: report of case treated with streptomycin. Bull. Charlotte Memorial Hosp., 2:44-47, 1946.

52. Zintel, H. A.: Streptomycin in peritonitis. Am. J. Med., 2:443-448, 1947.

53. Murphy, J. J., Ravdin, R. G., and Zintel, H. A.: Use of streptomycin in experimental peritonitis. Surgery, 20:445-451, 1946.

54. Foshay, L., and Pasternack, A. B.: Streptomycin treatment of tularemia. J.A.M.A., 120:395-398, 1946.

55. Abel, O., Jr.: The use of streptomycin in tularemia. J. Missouri M. A., 43:167-169, 1946.

56. Foshay, L.: A comparative study of the treatment of tularemia with immune serum, hyperimmune serum, and streptomycin. Am. J. Med., 1:180-188, 1946.

57. Howe, C., Coriell, L. L., Bookwalter, H. L., and Ellingson, H. V.: Streptomycin treatment in tularemia. J.A.M.A., 132:195-200, 1946.

58. Foshay, L.: Treatment of tularemia with streptomycin Am. J. Med., 2:467-473, 1947.

59. Spink, W. W., and Hall, W. H.: Diagnosis and treatment of brucellosis. M. Clin. North America, 29:343-362 1945.

60. Harris, H. J.: Brucellosis: advances in diagnosis and treatment. J.A.M.A., 131:1485-1493, 1946.

61. Spink, W. W., Hall, W. H., Shaffer, J. M., and Brande A. I.: Human brucellosis: its specific treatment with a combination of streptomycin and sulfadiazine. J.A.M.A. 136:382-387, 1948.

62. Kupperman, H. S., Greenblatt, R. B., and Dienst, R. B.: Streptomycin in the therapy of granuloma inguinale J.A.M.A., 136:84-88,1947.

63. Hinshaw, H. C.: Pyle, M. M., and Feldman, W. H.: Streptomycin in tuberculosis. Am. J. Med., 2:429-435, 1947

64. Hinshaw, H. C., and Feldman, W. H.: Streptomycin in treatment of clinical tuberculosis: a preliminary report Proc. Staff Meet., Mayo Clin., 20:313-318, 1945.

65. Cooke, R. E., Dunphy, D. L., and Blake, F. G.: Streptomycin in tuberculous meningitis: a report of its use in a one year old infant. Yale J. Biol. & Med., 18:221-226, 1946

66. Hinshaw, H. C., Feldman, W. A., and Pfuetze, K. H.: Treatment of tuberculosis with streptomycin: a summary of observations on one hundred cases. J.A.M.A., 132:778-782, 1946.

67. Howes, E. L.: Local chemotherapy of wounds. Tissue toxicity of certain antibacterial substances. Surg., Gynec and Obst., 83:1-14, 1946.

68. Pulaski, E. J., Kleinman, A. M., and Duncan, G. G.: Some considerations of the clinical application of streptomycin. Ann. New York Acad. Sc., 48:183-199, 1946.

69. Howes, E. L.: Topical use of streptomycin in wounds Am. J. Med., 2:449-456, 1947.

70. Hirshfeld, J. W., Buggs, C. W., Pilling, M. H., Bronstein, B., and O'Donnell, C. H.: Streptomycin in the treatment of surgical infections: report of experiences with its use. Arch. Surg., 52:387-401, 1946.

71. Strauss, M. J., and Warring, F. C., Jr.: Epidermal sensitization to streptomycin: report of six cases in twelve nurses handling the drug.

72. Heilman, D. H.: Cytotoxicity of streptomycin and streptothricin. Proc. Soc. Exper. Biol. & Med., 60:365-367. 1945.

73. Molitor, H., Graessle, O. E., Kuna, S., Mushett, C. W., and Silber, R. H.: Some toxicological and pharmacological properties of streptomycin. J. Pharmacol. and Exper. Therap. 86:151-173, 1946.

74. Hettig, R. A., and Adcock, J. D.: Studies on the toxicity of streptomycin for man: a preliminary report. Science. 103:355-357, 1946.

75. Brown, H. A., and Hinshaw, H. C.: Toxic reactions of streptomycin on the eighth nerve apparatus. Proc. Staff Meet., Mayo Clin., 21:347-352, 1946.

76. Farrington, R. F., Hull-Smith, H., Bunn, R. A., and McDermott, W.: Reaction to highly purified drug on long continued administration. J.A.M.A., 134:679-688, 1947.

PSYCHOSOMATIC MEDICINE AND THE OCCUPATIONAL THERAPIST

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THE principles of psychosomatic medicine are simple enough, but their application in therapy is difficult. Even the theory of such an application is quite involved and, often enough, it seems opposed to what we have learned to call commonsense. The pioneers of this new attitude in modern medicine are generally enthusiastic—sometimes, I confess, a bit expansive in their reports of its accomplishments. Their critics point out that the the work represents only a new, improved and intensified expression of the old family doctor attitude. We need not concern ourselves with this discussion. We are here more particularly to consider the inter-relationship of psyche and soma, of mind and body in the production of pathology and symptomatology important enough to attract attention.

Perhaps this doesn't sound altogether novel but, as I think you will come to see, there are some applications of the new knowledge which are not altogether commonplace. The idea that mind and body should be considered as a unit is not new, but modern research has underlined the closeness, the strength and the importance of their union. A few minutes spent in a review of fundamentals may refresh your memories and make my later remarks more intelligible.

At birth the child may be considered a helpless unit which, for convenience, we may, following Myerson's suggestion, call "ME." Everything else in the universe may be lumped into another unit ealled "NOT ME." The child immediately begins his task of adjustment to the "NOT ME"—an assignment which will only terminate with his last breath.

Although the infant lacks strength, coordination and intelligence, he is not without guidance, direction or purpose. Deep in his personality are instinctual drives which help to orient him in his relationship with the universe. For convenience these may be considered as (1) the drive to stay alive, (2) the drive to keep the race alive, and (3) the drive to keep his dignity alive.

At first his weapons in this contest are few and his efforts feeble. As he develops, his relationship with the universe becomes more involved and complex. With this he acquires resourcefulness in meeting difficulties, surmounting obstacles, solving problems. But he is often angered, disappointed, frustrated and depressed, just as he is often pleased, successful, comfortable and elated.

We are all familiar with the physical consequences of unhappy mental states. Compare the expression of the rejected suitor with that of the happy groom. Watch the gait of the successful business man and compare it with that of the father of a family who has been unemployed for three months. If you vomit at the sight of blood or develop goose pimples at a thrilling movie or faint when you meet with a sudden threat to your existence, you have a demonstration of how rapidly mental states may become translated into physical reactions without involvement of the will. The instances I have cited are commonplace. They are matters of common experience. They are so accepted even though the mechanisms behind them are not always understood.

The more complex and, accordingly, the more interesting problems in the field of psychosomatic medicine are those in which unconscious motivations are eventually found to be responsible for symptoms which the patient, his family, and even his physicians for a time may believe to have a somatic origin.

The Chinese say that one picture is worth a thousand words and perhaps one or two illustrations may be better than a prolonged exposition. The cases I am about to cite were seen years apart and miles apart. But their similarity and relationship will be obvious at the end of my report.

A very attractive Jewish girl came to the Vanderbilt Clinic complaining of troublesome indigestion and requesting a gastro-intestinal x-ray series. Her nutrition was adequate, her tongue was clean, her appetite was good and her elimination was satisfactory. Indeed, although she suffered from

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nausea and vomiting, these symptoms were by no means regular or frequent, but were related to a certain specific activity, namely, keeping a date.

So long as she limited her social activities to attendance at movies with her younger brother or going to Temple with her father, she remained physically comfortable, however isolated.

When she made an appointment to go out with a young man, she could be sure that before the evening ended she would be humiliated by an attack of nausea and vomiting. Naturally, when this had occurred two or three times with the same companion, explanations were coolly received and the relationship ended. She insisted that she had no other cause for anxiety, that she liked her job and that her domestic situation was comfortable. She was impatient with the examiner who insisted on inquiring about her emotional background.

Finally, it was discovered that during the previous summer she had met a dentist of her own faith who had become infatuated with her. She handled the situation well and tried to keep her emotions disciplined. She reminded him that their social positions were far from identical, but he insisted that this was inconsequential. They continued the relationship for some months when, for an apparently inconsequential reason, his calls became less frequent and he cultivated another contact. She was greatly disturbed and went to bed for two weeks, unable to eat or to sleep without sedation. Then she roused herself and returned to business, resolved to forget her late lover. In this she was largely successful because he no longer had an active role in her daily thoughts. But when she went out with someone else she was unconsciously reminded of the social and economic gap which existed between her present companion and her former suitor. This had the effect of making her say to herself, "This fellow makes me sick"—and he did.

A fourth year medical student in one of our larger cities left his fraternity house one evening to attend church services at St. Peter's. Final examinations were approaching and he was making regular trips to the church to pray for a successful graduation. On this occasion in the middle of the service he was seized with a spell of paroxysmal tachycardia. He became faint and and frightened. His pulse was so rapid that it could not be counted at his wrist. He got to a neighboring drug store where some remedy was provided and in another hour he was back home.

The next night he started again for the church but before he had gone two blocks he found hi tension rising. There was no tachycardia, but h was weak and frightened. He perspired and starte to return home. When he did so he began to fe a little better, gradually his strength returned, th perspiration decreased and he was soon all right.

However, he felt that it was cowardly to allo himself to be defeated by his imagination and h started back for the church only to find that hi symptoms again returned. Each block he felt mor uncomfortable and he thought he would have t give up. Next he tried a compromise. Instead o going to St. Peter's church, he decided to go t St. John's, which lay in a different direction. Ap parently this choice was agreeable to his uncon scious for again his symptoms improved and eventu ally disappeared.

He then returned to the point from which h had started for St. John's and decided to go to S Rose's. This choice met with no opposition and h felt that he could have continued in that directio without distress.

Returning again to the point which he had lef to go to St. Rose's, he started once more for hi original objective. Again his symptoms returne but he forced himself to continue. Neverthless, h finally reached the church considerably exhauste He had won the battle, but it had taken a goo deal out of him so that the return to the "frat house, a distance of some ten blocks, was mad with an effort although he was emotionally com fortable.

In this last case it may be noted that there wa no mystery about the obvious mental mechanism at work. This young man had undergone a trouble some experience in a certain locality. His intelli gence told him that there was no logical reaso for avoiding the locality because it had been th scene of a circulatory upset. But his unconscious acting through his instinct of self-preservatio tried to persuade him to avoid an area which th unconscious felt to be pathologically significan Although his reason and judgment were able t defeat his urge, it did not do so without a battl for which, since it involved his own psyche an soma, he was obliged to pay.

Increased experience with the physical misfo tunes of human beings, whether these are based o allergic, infectious, metabolic or traumatic disturb ances, serve to point up certain statistics whic

challenge our interest. It has often been said that roughly 65 per cent of the patients who consult the general practitioner may be divided into three groups:

Group "A" will consist of patients who consider themselves ill, whose appetites are poor, who sleep badly, who suffer from dysmenorrhea, constipation, hyperhydrosis, vertigo, lassitude, palpitation, etc. Careful and detailed physical and laboratory examinations fail to find a physical basis for these complaints.

In Group "B" there is obvious pathology in the digestive, circulatory or respiratory systems, for instance. But there is also a psychic factor which, while it remains, increases and intensifies the symptoms. When it is removed, the patient, though still handicapped, is a much more efficient machine.

Finally in Group "C" the psychogenic basis of such ailments as allergy, asthma, migraine and other forms of recurrent headache, essential hypertension and even epilepsy, is being carefully examined. It is certain that we are on the brink of further discoveries which will help in the understanding and control of these disturbing visitations.

It must be understood that the unconscious is not only the source of the instinctual drives which motivate human behavior, it is also a storehouse of memories, many of which we are willing enough to forget. Some of these have to do with events which carry an emotional charge of frustration, terror and guilt. They are not dead, although they appear to be asleep. This region, which has no clearly defined boundaries, contains much material which we have repressed, that is, automatically pushed out of consciousness because it is disturbing to what we call our peace of mind. Nevertheless such emotionally charged material often struggles for release and recognition. Its repression involves the expenditure of energy and constant vigilance. When this watchfulness is relaxed—as in sleep—the repressed material may appear in a disguised or more or less recognizable form as a dream. Battle dreams of soldiers suffering from so-called combat fatigue may illustrate this point.

Man is a gregarious animal and each sizable group of human beings has established its criteria of success. Each relatively normal member of the group strives to attain this success which has a negative as well as a positive side. In general he is expected to keep himself alive since his influence largely disappears when he is dead. He is expected, as a rule, to make his contribution to the perpetuation of the race, or at least to marry and establish a home. He is expected to support himself so that he will not be thrown on the charity of his neighbor. On the negative side, he must keep out of jail, he must avoid offending any sizable proportion of those with whom he comes in social contact. He must not indulge in eccentric or fantastic behavior which would expose him to censure or ostracism. To put it another way, he is given at birth three wild horses to ride and he must guide them with sufficient skill to keep himself alive, to contribute decendants to the race, and to get along with his fellow men in reasonable harmony. This is a complicated job and the universe in which he lives is another complex mechanism. It is not surprising, therefore, that temporary or lasting defeat is common and in some degree frustration is universal. Indeed, a consistent run of uninterrupted success would leave too little opportunity for the development of the higher virtues.

When defeat or detection appear the individual may react in various ways. Not always is his choice of solutions consciously motivated. Accordingly he may remain quite unaware that the muscle and joint pains from which he suffers result from the tension and resistance produced by his controlled impulse to strike someone who has frustrated him. He may see no relationship, even though it exists, between his chronic constipation and his miserly management of his money. It is the task of the physician interested in psychosomatic medicine (and I cannot see why that should exclude any member of the profession in clinical practice) to see that attention is given to the psyche as well as the soma when this is indicated. I may add that this is indicated much more frequently than most of the older group of physicians realize.

A woman of about 60 was brought to the hospital suffering from a strangulated inguinal hernia. She was operated on promptly and skilfully and her early convalescence was very satisfactory. In speaking with her one day about the promise of an early return to her usual activities, I noted that she exhibited little enthusiasm. I was curious about this and asked her the reason. She replied roughly as follows:

"I am 60 years of age and live on the third floor of a 6 family house. When I moved into that neighborhood 25 years ago, the people about me

were chiefly members of my own faith and my own race. Now my husband has been dead for a number of years and my children are scattered to different parts of the city and even to other cities. The same thing has occurred in the case of those among my old friends who are still living. What have I got to go back to? An empty house where I live alone with my cat. I must climb two flights of stairs once or twice a day. My children visit me when they can, but they have their families and other interests. They are good to me, but I can't expect them to live with me nor can I expect them to take me into their homes. Indeed, I would be quite as uncomfortable there as I am in my own flat. One day is much like the other. I have few friends in the neighborhood and I must ride several miles in a bus to call on one who lives anywhere else. My telephone is a help and I enjoy my victrola, but these things are not people."

And so the old lady lay there for another week or so. She was not eager to get up and about, she was not eager for anything but the end of her monotonous existence. And this came quietly, easily and gradually. No rise in temperature, no coronary occlusion, no bronchial pneumonia, no fall out of bed, but she simply died. I fancy I could have put down as the real cause of death, "She just didn't want to live."

It might be said in criticism of this illustration that the case was a most unusual one. This is admitted; the reason for using it as an illustration was to underline the strength of psychic influences in determining not only sickness or health, but life or death. For at least hundreds of years medical men have realized that anger, fears, apprehension, jealousy, anxiety, depression and feelings of guilt have profoundly influenced bodily states. On the other side of the ledger, ambition, patriotism and the cardinal virtues of Faith, Hope and Charity have lifted the human body far above its usual limitations and given it strength and endurance that approached the miraculous.

Impressive as these demonstrations may have been, they were commonly explainable. The annals of the Christian martyrs, the history of the concentration camps, the reports from the Warsaw Ghetto, detail heroic incidents which we could not hope to duplicate but which we may presume to understand.

In more recent years, however—taking the last quarter century as a convenient period in which to measure progress—the explorations of a number o sister sciences, notably psychology and psychiatry and particularly that form of psychiatry calle dynamic, have revealed additional data emphasizin the intimate cause-and-effect relationship betwee mental states and bodily ills. When I was a studen chronic anxiety was a psychiatric problem an peptic ulcer was a physical one. Now we kno that they are related, not occasionally, but fr quently and almost consistently. We know tha increased nervous tension promptly and directl affects the amount and composition of gastric juic the frequency and strength of the peristaltic wave the character of the circulatory function in th walls of the stomach. Various disturbances thu created frequently end in the production of peptic ulcer.

The "nervous" or tense individual often mak voluntary but perhaps unsuspected contributio to this result. To lessen his tension he becomes chain smoker. To relieve his initial gastric malais or improve his appetite, he sips cocktails. He drink highballs to dispose of depression. To enable hi to disregard the danger signs, he takes sedative thus perpetuating a vicious circle. With one end o this circle he is altogether too well acquainte with the other—the beginning—he has no consciou contact. He doesn't know where it all started, h is too busy trying to finish it.

Belladonna and bismuth, alkalies and anti-spas modics are drawn into the picture. Diet and drug sympathy and surgery are variously and often suc cessfully employed at least in providing relief. Bu altogether too often it is discovered that his diffi culty was not originally or primarily or even logic ally digestive but psychic. Not over-work, bu over-anxiety. He may be cheating on his incom taxes or he may be cheating on his wife. He ma find his type of life completely out of harmon with the principles acquired at his mother's knee Somewhere, sometime his trouble may well hav originated far from the mucous membrane whic lines the gastro-intestinal tract. But there, throug a mechanism not difficult for a modern student t understand, the blow falls and there, all to fre quently, the wound remains until the real cause o the trouble is discovered and eliminated.

I hope I am not misunderstood. Not all pepti ulcers originate from increased nervous tensio They do occur in placid individuals who are re markably well integrated and whose first sympton

ay be those of hemorrhage or perforation. But frequent and powerful is increased nervous ten- on as an etiological factor that no diagnosis is mplete until its possible influence has been ex- ored and no treatment is adequate which dis- gards it.

What has all of this got to do with Occupational herapy? Surely I am not trying to teach you agnosis. Much less am I attempting to make you, one lesson, skilful practitioners in the art of sychotherapy. But surely there is no reason why our work should become mechanically repetitious, o reason why you should not learn more about ie patient who is referred to you for the special elp which you can give.

Now that all the professional services are being taxed to the limit to make their contributions to the relief of human suffering, it is more than ever important that we should work efficiently and effectively. Many of you have unusual opportunities to sit behind the silken curtain, to establish rapport with the patient, to ascertain what unsuspected influences may have been at work in the production of his illness. I should not expect you to make the mistake of interpreting this material yourselves; still less would I suppose that you would modify your therapy in accordance with ill-considered conclusions. But you may well find yourself supplied with a wealth of valuable and significant data to spread before your Chief and to discuss with him the question which is always arising in medical work, "Where do we go from here?"

B.A.L. (2, 3 Dimercaptopropanol) IN THE TREATMENT OF ACUTE ARSENIC POISONING: A CASE REPORT

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The development of a detoxifying agent capable of counteracting the local and systemic effects of arsenic was given great impetus during World War II when an intensive search was made for an agent capable of neutralizing the action of lewisite gas. On the basis of their own work and that of others, English investigators[1] were able to demonstrate the theoretical and clinical effectiveness of an anti-lewisite compound, 2, 3 dimercaptopropanol which they designated as "British Anti Lewisite" or "B.A.L." It has been suggested by the Council on Pharmacy and Chemistry[2] that the name Dimercaprol be used as a non-proprietary synonym for B.A.L. since it suggests in an abbreviated form its chemical structure.

B.A.L. was received in this country late in 1941 for further study. These studies necessarily remained secret during the war but have since appeared in the literature. One of the most extensive series of cases of arsenic poisoning treated with B.A.L. has recently been reported in this country.[3]

The case here reported differs from most of those in the literature in that the poisoning was due to the accidental ingestion of arsenic. Cases reported in the literature are due, for the most part, to an accidental overdose, or to a toxic complication, of arsenic during the treatment of syphilis. This case is that of a child whereas experience to date has been chiefly with adults.

It is the purpose of this report to illustrate the simplicity and effectiveness of B.A.L. therapy now that it has become universally available.[4]

The patient, S. F., a 15 months old female weighing 20 pounds was admitted to the New Britain General Hospital on August 25, 1947 about 4 hours after eating the contents of one ant cap. Subsequent analysis of this ant cap revealed that it contained approximately 0.45 grains of metallic arsenic in the form of sodium arsenate in a honey base. The child had licked the contents of this cap over an estimated period of approximately 1½ hours. At the end of that time it was noted that the child had become somewhat listless. In another half hour she began to vomit. The vomiting which became progressively worse and projectile was accompanied by extreme thirst. For the latter symptoms, she was given large quantities of water to drink by her mother which she drank voraciously. Vomiting was followed by diarrhea, each persisting intermittently until the patient was admitted to the hospital. The vomitus and stools were of the same green color and consistency.

When examined at home, the child appeared semi-comatose. Her skin was cold and ashen gray in color and her nail beds slightly cyanotic. Her body was limp. Her pulse was rapid and her respirations markedly diminished. It was felt that she was desperately ill from acute arsenic poisoning and she was accordingly rushed to the hospital. Her appearance on arrival at the hospital was slightly worse than that described at home.

On admission to the hospital, B.A.L. was administered immediately in a dose of 0.25 cc. of the 10 per cent solution calculated on the basis of 2.5 mg. per kilo of body weight. This dose was given every 4 hours for 4 doses and then every 6 hours for 3 doses and then reverted to every 4 hours for 15 more doses, making a total of 22 doses. This amounted to 4.75 c.c. of B.A.L. in all over a period of 4 days.

Other and less specific supportive emergency measures were carried out as usual. A clysis of 250 c.c. of saline was administered while the patient was being blood typed and while the stomach was being lavaged with about 400 c.c. of 5 per cent sodium bicarbonate. First gastric washings were analyzed for arsenic and were reported as negative.

In a relatively short period of time, approximately one half hour, the child appeared improved. She was able to sit up with assistance and drink greedily a glass of Magnesium Sulfate which, however, she vomited projectively soon after. Her pulse seemed stronger and in view of her general improvement it was felt that her shock was not of sufficient degree to require a transfusion of plasma or of whole blood. Within the next six or seven hours it seemed probable that the child would survive the immediate acute episode. During the first twelve hours in the hospital the patient vomited projectively whatever food was taken by mouth. Her fluid intake was initially administered in the form of 2.5 per cent dextrose in saline clysis, the intake ranging between 1.5 and 2.5 liters daily all during her hospitalization. She continued to have loose watery, clear bowel movements of light green color for about 36 hours. These stools were not of the light rice water character usually described in acute arsenic poisoning. At times the stools contained mucous but at no time was any bleeding noted. There were approximately 10 loose stools during these first 36 hours of hospitalization following which the stools became soft and finally well formed.

The first of the voided urine specimens was positive for arsenic as determined by the Reinsch test. Subsequent urine specimens collected 48 and 72 hours after admission were both negative. This first specimen was voided about 16 hours after admission.

Twenty-four hours after admission the patient appeared to be very much improved; her abdomen was flat, soft and non-tender and at no time did she develop a rash or hemorrhagic tendencies. During this 24 hour period she cried frequently as though suffering from abdominal cramps which were felt to be due to her diarrhea, although it was known that B.A.L. itself in excessive amounts was able to produce irritability and other toxic symptoms. She was given codeine once for these cramps and sodium luminal frequently for restlessness.

On admission her temperature was 103 rectally and, in view of an inflamed throat, she was given Penicillin, 30,0 units every 3 hours prophylactically for 48 hours. A thro culture showed the usual throat flora. Forty-eight hou after admission her temperature was normal and remain normal.

While in the hospital, daily blood counts disclosed moderate hypochromic anemia for which she had bee treated previous to the poisoning. Blood studies were as follows: R.B.C.-3.0, Hgb.-59 per cent (9.2 gms.), WBC 5,100, with a normal differential. Subsequent blood studi in the office revealed no apparent depression of the bon marrow for as long as 2 months later. No red cells or cas were noted in the urine at any time.

On the 6th hospital day she was discharged, even thoug the parents were advised that she should remain a fe days longer. Follow up examinations revealed no sequela and recovery was uneventful.

DISCUSSION

This patient, a 15 months old child, ingeste about 0.45 grains of metallic arsenic in the for of sodium arsenate.[5] The lethal dose of metalli arsenic in an average sized male is about 3 grain although an accurate figure is of course difficul to determine. On this basis one might assume tha 0.45 grains could be a fatal dose in a 20 lb. child At any rate the child was semi-comatose and wa felt to be critically ill.

About 30 to 40 minutes following a single dos of B.A.L., the child appeared to be more alert an for the first time able to sit up with assistance an drink water. Up until the time therapy was insti tuted, it appeared probable that the child woul die. It seems unlikely that this rapid improvemen could be attributed to other supportive therap which consisted of gastric lavage and a saline clysi

The question of duration of therapy soon aros and the plan initially was to follow the routine o 2.5 mg. per kilogram every 4 hours for 2 days every 6 hours for 1 day and once daily thereafte for ten days or until complete recovery.[3,7] The dos of 2.5 mg. (i.e., .025 cc. of the 10 per cent o solution) per kilogram was used instead of th large 3 mg. dose since it was felt that subjectiv symptoms of B.A.L. toxicity could not be evaluate in an infant and that an overdose might inadver tently be administered. When chemical anaysis o the ant cap revealed a possible lethal dose, the dos age schedule, which had been reduced to 0.25 cc (25 mg.) every 6 hours, was increased to thi amount every 4 hours until the patient had com pletely recovered.

Inasmuch as the urine was negative for arsenic 3 to 72 hours after admission and the child appeared entirely well after four full days of therapy, A.L. was discontinued at this time. The suggestion that therapy be continued for 10 days is made apparently on the basis that a single ordinary dose of arsenic requires about 10 days for complete elimination from the body.[8] Apparently B.A.L. accelerated the rate of arsenic excretion[1,3] and it seems logical that duration of therapy might be determined by urinary studies of arsenic excretion rather than on an empirical basis.

Since toxic symptoms are for the most part subjective, they were, if present, difficult to evaluate in this child. Known reactions are nausea, vomiting, headache, burning sensation of the gums, nose, eyes and skin, profuse lacrimation and salivation, abdominal cramps, flushed face, tingling extremities, feeling of constriction of the chest and general restlessness.[1]

The vomiting and abdominal cramps were ascribed in this case to the toxic effects of arsenic rather than to those of B.A.L. The face was flushed and there was puffiness of the lower eyelids but no unusual lacrimation or salivation was noted. While the patient was ill, a suggestion was seen in the literature that the side reactions of B.A.L. could be relieved or prevented by the use of ephedrine 15 mg. orally or epinephrine 0.6 cc. of a 1:1000 solution intramuscularly.[9] Although probably effective, this medication did not seem necessary in this case.

For as long as 6 months after treatment, there have been nodules in both buttocks at the site of injection. These were initially painful but did not form abscesses. No other side effects of the drug were noted.

SUMMARY AND CONCLUSIONS

1. A case of accidental arsenic poisoning in a 15 months old child is presented which was treated successfully with B.A.L. with complete recovery despite the ingestion of a possible fatal dose.

2. B.A.L. (2, 3 dimercaptopropanol) or dimercaprol is a drug easily administered in a 10 per cent solution intramuscularly and should be readily available in every hospital for immediate use in arsenical and probably other heavy metal poisoning.

3. The dosage schedule and toxicity are reviewed and the use of arsenic urinary excretion tests as a means of determining duration of therapy is suggested although until such a procedure is substantiated the routine schedule should probably be followed.

REFERENCES

1. Peters, R. A., Stocken, L. A. and Thompson, R. H. S.: British-Anti-Lewisite (B.A.L.) Nature, London 156:616, 1945.

2. Council on Pharmacy and Chemistry. J.A.M.A. 131:823, 1946.

3. Eagle, Harry: The Systemic treatment of arsenic poisoning with B.A.L. (2, 3 Dimercaptopropanol) Jour. Venereal Dis. Inform. 27:114-121, 1946.

4. Hynson, Westcott and Dunning Inc., Baltimore.

5. Department of Analytical Chemistry of Conn. Agricultural Experiment Station.

6. Gonzalles, Vance and Helpern: Legal Medicine and Toxicology. D. Appleton-Century Co. 1937.

7. Waters, L. L. and Stock, C.: B.A.L. (British Anti-lewisite) Science, 102:601, 1945.

8. Goodman, Louis and Gilman, Alfred: The Pharmacological Basis of Therapeutics 740-743, The Macmillan Co., 1941.

9. Tye, M. and Siegal, J.: Prevention of reaction to B.A.L. 134: 1947.

TREATMENT OF A CASE OF SEVERE PRE-ECLAMPSIA WITH CONCENTRATED SERUM ALBUMIN (Salt-Poor)

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The etiology of pre-eclampsia is still unknown. However, as summarized by Hofbauer[1] our knowledge is crystallizing rapidly, yet until its cause is isolated the late toxemia of pregnancy in its severe form is still a complex and difficult therapeutic problem.

To date our mode of attack has been to treat the patient conservatively in the very acute stage, since any obstetrical procedure at this time leads to a higher maternal mortality. Sedation by morphine and/or barbiturates; lowering of blood pressure with veratrone; reducing neuromuscular irritability with magnesium sulphate; and stimulating diuresis with concentrated glucose intravenously has constituted our therapeutic approach.

However, when anuria develops all of these procedures are often of little avail. Dieckmann[2] used 6 per cent gum acacia in eclampsism and twice concentrated plasma was employed by Golden and Fraser.[3] With these reports in mind, concentrated serum albumin (salt-poor) seemed to be a sound physiological means of combatting the anuria of severe pre-eclampsia. With this new adjunct to the present therapy it was possible in the case here presented to bring about improvement in the patient so that delivery could be accomplished. It has long been known that terminating pregnancy usually results in immediate improvement of the patient.

CASE REPORT

S. A. was a 37 year old primigravida whose expected confinement was March 2, 1948. Past history revealed no cardiovascular or kidney disease. The prenatal physical examination was entirely normal. The patient had an uneventful antenatal course up to three days before admission to the Meriden Hospital. On January 26 she noticed ankle edema for which a salt deficient diet, ammonium chloride gms 1 t.i.d. and rest were prescribed. The edema cleared some under this regime, but on January 29 at 2 p. m. the patient had a BP of 145/95 and a 3 plus albuminuria. This was the first elevation of blood pressure and the first appearance of albumin in the urine. At 5 p. m. the patient was seen on admission to the Meriden Hospital and her BP again was 145/95. At 8 p. m. a BP of 200/100 was recorded and the patient appeared apprehensive with slight headache. Morphine 0.016 gm; veratrone minims 5; magnesium sulphate 10 cc. of a 25 per cent solution were given at once intramuscularly. The blood pressure dropped to 150/90 and remained so throughout the night. The blood pressure was recorded at hourly intervals and when it rose above 150/90 veratrone minims 3 were repeated. The patient presented a 3 plus edema of the legs and mild generalized edema. From the time of admission, at 4 p. m. on January 29 to 8 a. m. January 30, the patient voided 50 cc. of concentrated urine, sp. g. 1030 which boiled solid with albumin. The blood pressure was maintained at about 150/95 through the use of veratrone, magnesium sulphate intramuscularly, plus morphine and sodium amytal for sedation. Headache recurred about 9 a. m. with epigastric distress and vomiting. By infusion 300 cc. of twice concentrated plasma was given followed by 1000 cc. of 10 per cent glucose at 10 a. m.; 50 cc. of 50 per cent glucose was also given i.v. At 2 p. m. the patient was catherized and 30 cc. of concentrated urine which boiled solid with albumin was obtained. Consultation was had with Dr. A. H. Morse of New Haven who advised "cesarean section under local or spinal anaesthesia as soon as the patient could be gotten into condition for the operation." In the meantime serum albumin had been obtained and 10 gms. were given in 200 cc. of 10 per cent glucose by infusion at 3:30 p. m. The total serum protein determination was 4.15 prior to the use of plasma and serum albumin. At 6 p. m. the patient voided 275 cc. of urine which again boiled solid with albumin. Since this indicated definite improvement, it was decided that the patient would stand operation and this was carried out under spinal anesthesia at 10 p. m.; sedation was allowed to wear off so that the effect on the baby would be minimized. A living male infant weighing 4 lbs 12 oz. was delivered. 10 per cent glucose/water was administered during the procedure and morphine 0.016 gm given as soon as the baby had been delivered. The blood pressure remained about 150/90 during the procedure. It was noted at operation that all the tissues including the uterine wall were markedly edematous. Bleeding was minimal. 10 gms. of concentrated serum albumin was again administered i.v. in 200 cc. of 10 per cent glucose immediately at the close of the operation. At 4 a. m. January 31 catheterization obtained 400 cc. of urine, 4 plus albumin. At 9:30 a. m. 680 cc. of urine, 3 plus albumin. At 12 noon patient's blood pressure rose to 200/100 and it was necessary to repeat veratrone, magnesium sulphate and morphine. A third 10 gms. of albumin was administered in 200 cc. of 10 per cent glucose and followed by 500 cc. of 10 per cent glucose in distilled water. In 24 hours following operation 4250 cc. of urine were excreted. The patient's general condition was markedly improved although the blood pressure

is still labile. Veratrone was continued if the blood pressure exceeded 170/100. On the 2nd postpartum day the serum proteins were 4.86. For the first 12 hours of this day the urinary output was 650 cc. Serum albumin 10 gms. was administered and in next four hours the output was 1000 cc. On 4th postpartum day serum proteins had risen to 5.7 gms. per cent.

TABLE I

	1/30	1 1/31	2/2	2/4
albumin	2.81	.....	2.84	3.37
Glob.	1.34	.....	2.02	2.20
Protein (total)	4.15	.....	4.86	5.57
Sugar	184.	.....	.....	.....
BUN	31.2	31.7	35.5	29.4
Creatinine	2.95	.....	.....	.....
Uric acid	3.1	3.5	.....	.....
Cholesterol	.....	.....	229	.....
Chlorides	521.	561	511.5	552
Urea N	21.3	.....	.....	.....
Thalphalin floc.	.....	2 Plus (48 hr.)	.....	Trace (48 hr.)
Albuminuria	Boiled solid	4 plus	3 plus	2 plus

The patient's general condition improved steadily with gradual disappearance of the edema. The blood pressure stabilized about 150/90, albuminuria decreased to 2 plus. The patient was allowed out of bed on 5th postpartum day and discharged on the 11th postoperative day, still running 2 plus albuminuria and a blood pressure of 150/90. On the 7th postpartum day the blood pressure was 130/80, urine 3 plus albumen.

The rationale behind protein therapy in eclampsia has accumulated from the work of Dexter et al,[4] Rinehart[5] and others. Proteins begin to fall in the 3rd month of pregnancy and reach a minimum in the 9th month.

TABLE II*

	TOTAL SERUM PROTEINS GMS PER CENT	ALBUMIN GMS PER CENT	GLOBULIN GMS PER CENT
Non-pregnant female	6.94	4.96	1.99
Pregnancy	6.7	4.4	2.3
Toxemic pregnancy	5.6	3.5	unchanged

*After Rinehart.

The liver, the vulnerable organ in eclampsism, has been shown to be the principal organ concerned in the manufacture of serum albumin. Various investigators have found that the ability of the liver to synthesize or dispose of various substances is markedly impaired during the latter half of pregnancy and even more so in toxemic pregnancy. Novak and Lustig[6] feel that the tendency toward salt and water retention is probably caused partly by an increased function of the adrenal cortex which is in general markedly enlarged in pregnancy and partly by the large amounts of estrogen and progesterone in the maternal organism. No matter what the ultimate sequence of events is found to be, we know that in severe pre-eclampsia disturbed water metabolism, as has been so clearly pointed out by Chesley,[7] plus a falling blood protein level can only lead to anuria when the proteins fall below the edema level. Up to a certain point, salt depletion, high protein diet and ammonium chloride as a diuretic are helpful, but once anuria has set in the only rational therapy is protein replacement. The albumin fraction has been shown to be the fraction which varies, the globulin remaining relatively stationary.

Taking 225 gms as the average total serum proteins in pregnancy we find in this case albumin decreased 36 per cent and total protein 38 per cent, or mainly a decrease in the albumin fraction; a total protein decrease of 95.5 gms. We replaced 40 gms in the form of concentrated serum albumin (salt-poor) and 500 cc of plasma or approximately 35 gms of total protein for a total of 75 gms of replaced protein. At the conclusion of therapy the patient had a total protein of 5.57 gms per cent, still 15 per cent or about 20 gms below normal.

It would appear that the protein level may be a better index of the severity of pre-eclampsia than the uric acid determination. In keeping with this conclusion is the fact that anuria is a sign of most serious import and that unless diuresis can be effected improvement usually fails to take place.

CONCLUSION

In serum albumin (salt-poor) we have a potent therapeutic aid in the treatment of the anuria of severe pre-eclampsia. This should be used in conjunction with the standard treatment.

REFERENCES

1. Hofbauer, J.: Am. J. Obst. & Gynec. 51:514-518, 1946.
2. Dieckmann, W. J.: Am. J. Obst. & Gynec. 22:351, 1931.
3. Golden, A., Fraser, G.: Am. J. Obst. & Gynec. 54:523-528, 1947.
4. Dexter, Lewis, Weiss, Soma et al.: J.A.M.A. 122:145, 1943.
5. Rinehart, R. E.: Am. J. Obst. & Gynec. 50:48, 1945.
6. Novak, J., Lustig, B.: J. Mt. Sinai Hosp. 14:534-541, 1947.
7. Chesley, L. C., Chesley, E. R.: Am. J. Obst. & Gynec 45:748-761, 1943.

INTRAVENOUS PROCAINE BELOW TOURNIQUET FOR SURGERY OF THE EXTREMITIES

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THE method of inducing anesthesia in an extremity by intravenous injection of a local anesthetic drug distal to a tourniquet may certainly be said to be in complete disuse at the present time. Accordingly it seemed worthwhile to re-evaluate this method clinically, and by comparison with alternative methods to find what place, if any, this technique might have in present day practice.

August Bier in Germany was the first to use this method in 1908.[1] Goyannes[2] in Madrid shortly thereafter used the artery of the limb as a vehicle for cocaine employing an arterial tourniquet. Ransohoff[3] later modified the technique by arresting the return circulation. By 1912 Hayward[4] in Bier's clinic had collected 375 cases. The method enjoyed some popularity for a brief time after its inception. Since then there have been intermittent reports of its use. Arland[5] in India appears to have been the chief protagonist during the following decade.

Adams[6] in 1944 reviewed the subject and the composite reports of 500 cases by various authors indicating success in 90 per cent of cases. He was unable to find any report of a death attributable to this method.

Herreros[7] in 1946, employing pontocaine, reported the use of this method in 104 cases with no failures or complications.

THE TOURNIQUET

The tourniquet is an integral part of this anesthetic technique. Its misuse may cause serious injury. Speigel and Lewin[9] in 1945 reported 3 cases of permanent peripheral nerve damage following elective use of rubber tourniquets for surgery in U. S. Army hospitals. The injury was proved by surgical exploration of the involved nerves. They were able to find records of only 2 permanent and 16 temporary paralyses from this cause in all the literature. I seemed likely to them that many cases were n reported. The surgeon who uses a tourniquet ele tively will rarely delegate its application to anothe The anesthetist should do no less.

To the surgeon, the use of an arterial tourniqu offers many advantages. These have been admirabl stated by Bunnell[8] who says "It is impossible as we as dangerous to dissect a hand properly without th aid of ischaemia from a tourniquet. The hand i exceedingly vascular and is filled with tiny struc tures that will be covered with blood which i opaque, so instead of progressing without dissectio we will be fumbling, traumatizing the tissues b forever sponging and the tissues will be crushed b too many hemostats."

There are three types of tourniquet in use at th present time, namely:

(1) Rubber tubing.

(2) The elastic bandage. This includes the Marti and Esmarch bandage.

(3) The pneumatic type. The sphygmomanomet cuff and the Campbell-Boyd type[10] fall in this grou

From an experimental study of tourniquet paral ysis, Denny-Brown and Brenner[12] concluded tha the onset of paralysis is in general more rapid th greater the applied pressure, where short segment of peripheral nerves are compressed. Hinman[13] ad vocates the use of a blood pressure cuff blown up t 70 m.m. of Hg. above the systolic pressure. By actua measurement, he has shown that the proper tensio is very difficult to obtain with the Esmarch bandag and the rubber tubing tourniquet. According t Bunnell,[8] the blood pressure cuff apparently neve causes paralysis in the arm. Blown up to 300 mm. o Hg., it may be kept on safely for 1½ to 2 hours McElvenny,[11] whose experience extends to thousand of cases, says that under no circumstances is an tourniquet, except a pneumatic type, allowed on th upper extremity. In this study the blood pressur

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iff wrapped around with a muslin bandage and own up to 300 mm. of Hg. was used as a tourniet. The limb had previously been exsanguinated y spiral wrapping with an Esmarch bandage up to ie inch from the tourniquet[8] or by elevation for minutes.[13] It was applied to the mid-portion of the m and thigh and in a few cases to forearm and leg. lthough Hinman[13] maintains that the forearm and g are safe places to apply a tourniquet, this has en objected to on the ground that the interosseous ssels are difficult to compress and that the viability the skin which overlies the subcutaneous surface the tibia is endangered. In general, the tourniquet on forearm or leg, although it permits the use of naller amounts of procaine solution, often enroaches upon the operative field.

The following precautions should be observed ith the use of the tourniquet:

1. The tourniquet should not be used in arteriolerotic subjects, diabetic gangrene and other contions in which the arterial supply has been long npeded by vascular disease. It may lead to gancene of the peripheral part.

2. No tourniquet should be applied at or close to ie knee or elbow joint to avoid injury to common roneal and radial nerves.[13]

3. Solutions used in the surgical prep should not allowed to wet the cuff. Evaporation beneath a ourniquet is slow and a burn may be caused.[11]

4. Where the tourniquet is to be left on for long eriods of time, it is desirable to keep the limb cool id thus to lower the metabolic processes in the esence of ischemia.[13]

5. Sudden flexion or extension with the tourniquet place may lead to subcutaneous tearing of undering muscles and nerves.[14]

6. Cuffs with metal ribs are not suitable as tourniets. It was used in one case in this series and proiced moderately severe bruising of the skin.

7. Although opinions vary, the time limit for connuous application of one to one and one half hours ppears safe.

8. Tourniquets should not be permitted to leak as idenced by bleeding into operative field or presnee of a palpable pulse distally. Over a period of me, this may lead to bursting of capillaries and trusion of blood into the tissues. McElvenny[11] aims to have seen a complete Volkmann's type of ralysis following such an event.

CLINICAL CASES

The method of inducing anesthesia in an extremity by the intravenous injection of procaine was used 41 times in 40 cases, anesthesia having been induced in both arms consecutively in one case. The cases were as follows:

1. Debridement and repair of lacerations—16 cases.
2. Closed reduction of fractures—7 cases.
3. Incision and drainage—4 cases.
4. Excision of ganglia, tumors, cysts, etc.—13 cases.

Although the barbiturates are recommended for premedication, the patients in this group received morphine, atropine, or the two combined in doses used for other forms of anesthesia. Fourteen outpatients received no premedication. A 1 per cent procaine HCl solution in distilled water was employed in all instances. The use of a 22 gage needle and pressure on site of venipuncture prevented leakage. Tourniquets were left on for periods varying between ten minutes to two hours. Difficulty was experienced with tourniquet pain after one hour. Intravenous morphine and release of the tourniquet for periods of 2 minutes was resorted to. After the final release of the tourniquet, response to painful stimuli returned in from 4-15 minutes. The amount of procaine used was determined by skin testing with a pin at or around the operative site with the needle still in place in the vein. Anesthesia of the deeper structures was always present when skin analgesia existed. This fact was noted by Morrison.[15] The following range of dosage was employed:

Tourniquet on forearm
25-35 cc. of 1 per cent Procaine HCl
Tourniquet on arm
40-70 cc. of 1 per cent Procaine HCl
Tourniquet on mid-leg
30-60 cc. of 1 per cent Procaine HCl

This large variation in dose is greatly influenced by the site of venipuncture in relation to operative area. If the puncture is made close to the site of operation, less drug will be required due to the manner of diffusion through the vascular tree.

The smaller dose used in lower extremity anesthesia was due to the venipuncture close to operative site and the interposition of a tight venous tourniquet between the venipuncture and arterial tourniquet during course of injection. The dosage in children was about half the adult dose.

RESULTS

After release of tourniquet, no effect was noted on respiration. Cardiovascular effects were in general, not significant. However, in 4 cases a rise in pulse rate of 20 or more was noted, accompanied by a slight fall in both systolic and diastolic pressures in one case. In one case, the pulse rate dropped from 100 to 84 and the blood pressure rose from 90/40 to 118/60.

Adequate and immediate anesthesia was obtained in all but four cases. Three of the latter occurred early in the series and were due to inadequate dosage. The fourth case, a young adult, was brought to surgery about one hour after a traumatic amputation of four fingers of the left hand through the proximal phalanges. A rather large dose of 80 cc. failed to give adequate anesthesia. It was noted that very little bleeding was occurring at the stumps. When Bier[16] used adrenalin with his solution, he noted that many areas of skin remained sensitive and attributed this to a spasm of the vessels. It is possible that a similar mechanism operated here. Also an insufficient waiting period was allowed for the onset of so-called "indirect" anesthesia: i.e., one due to infiltration of nerve trunks at a higher level.

One patient, who was seated at the time of the release of the tourniquet, experienced a sensation of warmth and tinnitus which lasted 3 minutes. One case of bruising of the skin occurred where a metal-ribbed blood pressure cuff was used as a tourniquet. Two cases suffered more than usual postoperative bleeding. This may indicate one of the disadvantages of this method. The surgeon has the alternative of releasing the tourniquet before the completion of the operation, tying bleeders quickly and effecting a rapid closure or releasing the tourniquet only after the operation is concluded and a fairly tight dressing has been applied.

Determinations were made of blood procaine level by the method of Bratton and Marshall modified by Graubard et al.[17] in two adult patients of comparable size, receiving 60 cc. of 1 per cent procaine in an arm with obstructed circulation. Blood from the vein used for injection showed in Case I fall from 200 mg. per cent at one minute to 48 mg. per cent at 20 minutes. In Case II, a level of 64 mg. per cent at one minute fell to 32 mg. per cent at 10 minutes. Blood was taken from the ante-cubital vein of the opposite arm two minutes after the release of the tourniquet. In Case I, the tourniquet was released 30 minutes following injection of procaine and a blood level of 0.3 mg. per cent was found. Case II, in which the tourniquet was released 15 minutes following the injection, gave a level of 1.3 mg. per cent. This may indicate that the customary waiting period of 20 minutes to one half hour before the release of the tourniquet had best be observed although release after shorter intervals in several cases had no apparent ill-effect.

DISCUSSION

An unanticipated good result with this method was obtained in 6 children aged 7-12. The suggestion is made that in the traumatic surgery of the extremities in children who have recently eaten, this method may prove very useful since general anesthesia is so often associated with disturbing emesis and the degree of cooperation necessary for other forms of regional anesthesia cannot usually be obtained.

If the method is as safe as it appears and since the only skill required is that necessary to perform rapid venipuncture, it seems suitable for use in certain military establishments in time of war. Casualties may be very heavy, anesthetists absent or in short supply, and ambulatory patients are desirable. Oddly enough, it has not been used in the two wars occurring since its inception.

SUMMARY

1. A short history of the method is given.

2. The use of the tourniquet is reviewed and precautions outlined.

3. Clinical cases done are discussed.

4. Possible uses in present day practice are discussed.

The method of inducing anesthesia in an extremity by the intravenous injection of procaine hydrochloride distal to a tourniquet is briefly reviewed, emphasizing the literature published and the uses and misuses of the tourniquet. A review of the results of 41 procedures is given with comments on clinical usefulness and dangers.

Determination of blood procaine levels through the courtesy of Dr. P. D. Rosahn.

REFERENCES

1. Bier, August: Ueber einen neuen weg Lokal anesthesie an den Gliedenmassen zu erzeugen. Arch. f. Klin Chir. 86:1007-1016, 1908.

2. Goyannes, J.: Un nuevo metodo de anestesia regional. Rev. Clin. de Madrid Nr 1. (Abstr.). Zentralbe f. Chir. 38: 1600-1601, 1911

. Rausohoff, J. L.: Terminal Arterial Anesthesia. Ann. urg. 51:453-6, 1910.
. Hayward, E.: Erfahrungen und Beobachtungen an 375 allen Von Venenanasthesie. Arch. f. Klin. Chir., 99:993-015, 1912.
. Arland, J. P.: Intravenous Anesthesia in Surgical Prac-ice. Indian M. Gaz., 60:210-213, 1925.
. Adams, R. C.: Intravenous Anesthesia. N. Y. Paul B. Hoeber 1944 p. 122.
. Herreros, L. G.: Regional Anesthesia by the Intrave-ious Route, Anesthesiology, 558-560, 1946.
. Bunnell, S.: Surgery of the Hand. V. B. Lippincott Co. 944, pp. 90-91.
). Speigel, I. J. and Lewin, P.: Analysis of 3 case of surg-cally proved Peripheral Nerve damage following use of rubber tourniquet. J.A.M.A. 129:432-5, 1945.
o. Campbell, W. C.: Operative Orthopedics, St. Louis. C. V. Mosby Co., 1939, p. 108.
11. McElvenny, R. T.: The Tourniquet, Its Clinical Application. American Journal of Surgery, 69:94-106, 1945.
12. Denny-Brown D. and Brenner, C.: Paralysis of Nerve induced by Direct Pressure and by Tourniquet. Arch. of Neurol. & Phych. 51:1-26, 1944.
13. Hinman, F., Jr.: The Rational Use of Tourniquets, Int. Abstr. of Surgery 81:357-366, 1945.
14. Reid, Mont R. and Andrus Dew.: Nelson New Loose Leaf Surgery. Vol. 1, p. 676.
15. Morrison, J. T.: Intraveneous Local Anesthesia. Brit. J. Surg. 18:641-7, 1931.
16. Bier, August: Ueber Venenanesthesie. Berlin Klin. Wochenschrift 46:477-89, 1909.
17. Graubard, D. J., Robertozzi, R. W. and Peterson, M. C.: Microdeterminations of Blood levels of Procaine Hydrochloride after Intravenous Injection. Anesthesiology 8:236-40, 1947.

ORGANIZATION RESPONSIBILITIES OF COUNTY MEDICAL SOCIETIES

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The County Medical Societies are the foundation of organized medicine. In order to assure a good structure for organized medicine it is necessary that the foundation be sound.

If we are to have excellent county medical societies we must pay attention to the selection and maintenance of membership in these societies. All ethical physicians in a county should belong to their medical society.

Too many of our county societies have rules regarding application for membership that were made in the horse-and-buggy days. When traveling physicians with little or no formal education came to a community and started a practice, it was very difficult to obtain any information regarding these new physicians as communication was very slow and it was very necessary to have a long waiting period in order to evaluate these men. With today's method of education and licensure in this country, I question the necessity and the advisability of requiring a young physician to wait a year before his application for membership shall be considered. An alert board of censors can easily obtain information about a new physician in the county in a very short time.

One of the best avenues of information is the state medical examining board. This board must have all the information on an applicant before he can be granted a license, either by examination or through reciprocity with another state or by recognition of national boards. The medical school from which the applicant was graduated, or the hospital where he was an intern, also may give valuable information.

If there is any question about the applicant the board of censors can so state and action on his application can be deferred. If, as in most cases, his credentials are satisfactory, he can immediately be brought into his county medical society.

We cannot expect all members of a society to take an active interest in its affairs and progress, but every effort should be made to increase the interest of individual members and give them the opportunity to contribute to the welfare of the society.

One suggestion that I have is that new members should be questioned regarding their special interests

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and records of these be kept for future reference. In this way the right man for the right job can more readily be found.

In the selection of committees, we must search diligently for men who will be interested, and while our committees should be representative not only as to the field of practice, but also the various communities in the county must be represented, nevertheless, the committee members should primarily be selected for their ability to carry on the work of the committee.

To operate a county medical society requires a certain amount of inside and outside politics. These politics should be carried on with a single objective: namely, to improve the society in its service to the public and to its members. Too many medical societies are maintained by one physician or a small group of physicians. Our medical societies must not be "private clubs" run by a few physicians in the county.

Another problem is the maintaining of ethics. It is amazing the ignorance of many young physicians with respect to this subject. While medical ethics are usually discussed in medical school, most young physicians have only a general idea as to the conduct expected of them, and there are many phases of ethics about which they are unacquainted. A solution of this problem would be a short indoctrination course consisting of lectures on ethics in every day practice. In this way rules for their conduct would be thoroughly understood by new members.

Even though we have a good indoctrination course in medical ethics, we must remember that young physicians joining our society will be influenced by the ethics or lack of ethics of older members. Many of our societies are very strict about allowing physicians to join them and extremely lax in their censorship. If we allow a percentage of our members to practice unethically, the entire society is punished. Many times I have heard it stated that 10 per cent of the physicians cause 90 per cent of our poor relations with our lay public.

If we are to maintain good ethical standards in our societies, our board of censors must be active. Our members must be willing to report wayward physicians. Only a handful of flagrant violations need be judged in order to elevate the standards of medical ethics.

I realize that the questioning and judging of a physician's ethics is a disagreeable task. However, we have a monopoly on medical care, and if we are to maintain our position in this country we mu accept the responsibility of maintaining ethics in ou county societies. This is not a job for the Americ Medical Association, or the state medical societies. is a job for the County Medical Society.

The public also must realize that we have mechanism for hearing their grievances again physicians. It would be far better for one of ou aggrieved patients to consult an informed committe of the county society where their grievances can b intelligently settled, than to have them writin letters to newspapers and talking to their friends an relatives.

It is my opinion that our relations with hospita require very thoughtful and careful management. question the requirement that no physician be a lowed on a hospital staff until he becomes a membe of his county society, unless we are willing to chang the membership rule that states that a physician mu be in the county 6 months to a year, and in som cases longer, before he can become a member of h county society. I believe a physician should b allowed courtesy privileges in a hospital as soon he starts to practice in the county, if he is approve by the hospital directors.

As to the members of our county societies who ar engaged on a full-time basis for a hospital, much ea be done by the society to see that these physician are not exploited financially by the hospitals. How ever, this matter must be handled thoughtfully an carefully.

The selection of a medical staff of a hospital entirely the responsibility, in most institutions, o the board of directors of the hospital. I am sure tha the blame for most of the difficulties associated wit staff appointments and courtesy privileges in hos pitals should not be placed on boards of directors o hospitals, but should be placed on members o groups of members of our own societies. Thes physicians, occasionally for selfish reasons, bu usually on account of inability to view objectivel the entire field of medical practice, have exerted un due influence on hospital directors. The resultin rules and regulations regarding staff appointmen leave much to be desired.

Because of the inequalities between the prestig and power of specialty groups and general pract tioners, the problem of hospital relations is ver difficult to solve within the confines of the hospita However, in our county societies, all members hav an equal vote and the privilege of discussion.

If we, in our county societies, will give careful onsideration to the medical staff problems of hos-itals in our county, and show good judgment in aking any suggestions, I am sure that most hospital oards of directors will recognize, and in many ases, welcome our suggestions.

In concluding these remarks regarding Organiza-ion Responsibilities of County Medical Societies, I vish to emphasize:

(1) That the societies must carefully select and naintain their membership, not by old rules, but by being alert to new physicians in our county. We must keep our members active and alert and remember that the County Society is not a "private club."

(2) At the peril of losing our prestige with the public, we must judge the ethics of our members fairly and fearlessly.

(3) Much can be done with hospital relations, but we must remember that most hospitals are managed by a board of directors, and we must exert our influence carefully and thoughtfully if our suggestions are to be welcomed by these groups.

A COMMENTARY ON FULL TIME TEACHING

HAROLD SAXTON BURR, PH.D., *New Haven*

The Author. *E. K. Hunt Professor of Anatomy, Yale University School of Medicine*

IN RECENT months there has been much discussion of the high cost of Medical Education. The mplication is that preparation for a learned pro-ession is unduly expensive. This slant on the prob-em undoubtedly derives from the fact that in many nstitutions financial officers concern themselves ot only with their custodial duties of funds, but l o through their control of expenditures exert great influ nce on policy. The result is unfortunate, for most financial officers have little exp:rience with teaching and research and little understanding of th: wide range of activities in a university. That the price paid for a medical education is unduly high may be easily disproved.

There can be no question that medicine is a learned profession. To be a physician demands an abiding curiosity about man and the nature of things, and a sincere desire to be of service to the community. The staggering range of information a physician must have if he is to contribute to his day and generation means a long and arduous training period, the extent of which ranges widely over human knowledge. The physician must be not only competent in the technical aspect of medicine, but also must have an understanding of human beings and their relation to society and the world about them. Such a comprehensive experience requires top flight teachers, elaborate laboratories, and very real freedom for research. All of these are necessarily expensive, and rightly so. If one stops to think of the enormous dependence of mankind on collective and individual health, one will realize that no cost is too high to prepare man for the job of maintaining that health. While the sickness rate is distressingly high, how very much worse it would be if it were higher! Human activity in all its manifold aspects would be seriously crippled if it were not for the fact that so many of us are reasonably well. All of which means that instead of fighting higher costs of medical education, all institutions concerned with the training of physicians should be looking for more funds to improve the calibre and the quality of trained doctors. This does mean of course, that there may be places where funds could be more advantageously spent.

One of the large items in any institution is the sum paid to faculty members for their services in teaching and research. Institutions of higher learning rarely can compete with industry. While it is true that really first class men are rarely motivated by salary considerations, nevertheless, one cannot depend too greatly on the selfless devotion of individuals to the fields of their choice. Fortunately, the type of individual who makes the best teacher and investigator has no particular desire to subject himself to the necessary restrictions of the workaday world. Good teachers and good investigators

and good doctors are born, not made. They come equipped with a driving interest in a particular field which makes them relatively indifferent to financial matters, except those involved in an ordinary decent standard of living.

Because doctors are born, not made, because they do have a consuming interest in people and ideas, another aspect of the problem crops up. Probably no profession in the world is as individualistic as medicine. The whole success of the physician stems chiefly from his ability as an individual to analyze the problems of patients and to synthesize some method of assistance. In spite of the enormous technical development in modern medicine, the good physician still must rely on his own individual knowledge and ability. A hundred or more years ago no one questioned this because the general philosophy, at least in Western civilization, was centered on the individual. Interestingly enough, this concept of the paramount importance of the individual grew out of the scientific theory of evolution which called attention to the fact that in the long range of evolutionary history each successive stage showed the appearance of new characters which tended to segregate each member of the species more and more sharply from others of that species. Most of us would find it difficult to recognize an individual fish or frog. With cats and dogs, however, a single animal can be recognized as different from all other animals. But that difference is based on relatively few characteristics. When, however, we come to primates and man, the number of characteristics which differentiate them from others increases enormously. So much so, that it may be said without fear of contradiction, that there are no two human individuals alike anywhere in the world. Mother Nature very clearly laid emphasis upon the development of uniquely different persons as the most valuable acme of the whole evolutionary process, at least so far as is known. In such an environment physicians flourished, because medicine is a personal and individual affair.

However, since the turn of the century, or thereabouts, the great technicological development in communications and transportations and in mass production have tended to emphasize corporate rather than individual activity. A new "good" emerged. No longer was it good to realize completely, or as completely as possible, the aptitudes, capabilities and virtues of the individual; but rather to add to this a higher good, that of Society. Mo of the isms of this century have arisen from th shift in values and the result has been disastrou for now great masses of people no longer rely o their own intelligence, integrity and independenc but shift the responsibility to some outside agenc No longer does a man have to carry out his ow destiny; rather the world owes him a living. N only a living, but a good one. No matter wh their deficiencies may be, they expect to be care for economically, through Social Security; educa tionally, through government financed educatio and medically, through some scheme of Socialize Medicine. This modern concept has had its pr found effect upon medicine, for everywhere on hears a demand for more and better medical ca at lower prices and for everyone to be provided f by some mythical government agency. Through r distribution of funds, the rich and successful pay f the poor or incompetent. This last is, of course, n new doctrine, for physicians, as individuals, hav been following it for generations. But now it proposed to take it out of their hands and put into the hands of some outside group. It woul seem reasonably clear that this group control ov the individual is irrational. Quite justifiably, th physicians realize this and resist the new progra Moreover, if one scans the record, it would appe that the proper activities of the individual (an what is the use of education if it is not to defin "proper?") need not necessarily be in conflict wit the "good" of the whole group. We are all mem bers one of another; that cannot be denied.

It is equally true that many individuals hav abused this right of individuality to become pirate preying on their fellow men for their own advan tage—"improper" individuals, in every sense of th word. This is not the fault of individuality, bu the fault of education. Medicine is not free fro profiteering but, unfortunately, it is impossible t legislate ethics. To do so just shoves the thin underground. It can be weeded out only by th highest standards of education, which brings u right back to where started: To supply the righ kind of education there is needed first of all th right kind of teachers and investigators who ar supplied with adequate laboratories and with ad quate funds for research. This means careful selec tion of personnel, to crowd out the profiteer More than anything else, it means freedom for th "proper" individual to develop his individual apt tudes and abilities for the highest service to h

ıy and generation. This was one of the cherished ›pes implicit in full time medicine.

During the last century, there developed in this ›untry many schools of medicine operated by :acticing physicians, which eased some of the fficulties of the apprentice method. Many of these stitutions trained successful physicians. Unfor-ınately, however, others exploited the schools for ıeir private benefit. With the development of niversity education in medicine, the clinical aching was done entirely by practicing physi-ans. Needless to say, among these were some who ploited their university connections, again for ıeir own advantages. It is not surprising, therefore, ıat just before the turn of the century, a number educational leaders, concerned with what seemed be a growing danger to medical education, anned a medical school in which all full profes-›rs would be engaged to devote their entire time the affairs of the institution. For this they were receive adequate salaries. Their responsibilities ould include training men in medicine, advanc-g the science of medicine, and caring for a limited ımber of the sick. It was hoped that this program ould free able clinicians from the exigencies of ıe private practice and enable them to advance gnificantly the whole field of medicine. This as, of course, a laudable ideal. In theory it has ıuch to commend it. Ideally, it would attract the ›lest men and provide them with the necessary :ademic freedom for the advancement of medi-ıe. Sound as this whole program was, in many :spects, it failed completely to take cognizance of ıe fact that able men do not arrive as the result f some organizational fiat. It is not too difficult ›r a group of intelligent men sitting around the ble to dream up beautiful programs. It is, how-ver, extraordinarily difficult to find the right kind f men to implement such programs. Opportunity oes not necessarily create the individual. And yet ıe success of any program is completely depend-ıt on the fact that in order to be a success, must e carried out by individuals who find in the pro-ram a basic concept to which they can devote ıeir entire loyalty. Thus, at the very outset, a aradox is encountered. Generally, able men are ways individualists with their own independent leas and hopes. They are not the kind, therefore, fit easily into schemes established by other people, specially when such programs are often organized y men who, themselves, are not compelled to carry out the plans. Every organizational scheme depends in the last analysis upon the ability and capacity of the individuals who implement the program. It succeeds or fails at this point alone.

It so happened that the first full time program in medicine turned out to be eminently successful, because of the genius shown by the head of the institution in selecting the first incumbents. It was these individuals who made the plan work. Without them the scheme could have accomplished nothing. It is not surprising, therefore, that other institutions, in an attempt to emulate the first example, assumed that the program was in itself sufficient; that able men would automatically gravitate to such a program and that it would, therefore, result in equally effective schools. Fortunately, circumstances made it reasonably obvious that this faith was in part justified, with the consequence that more and more institutions adopted full time medicine as an effective program. Eventually the plan came to be an end in itself, thus forgetting the importance of the personnel.

In the course of the years, a number of difficulties have arisen. The first of these can be dismissed summarily because it is so obvious. Full time medicine is an exceedingly expensive program. Much too expensive for many institutions. It is pertinent, therefore, to ask the question, "Is it worth it?" This question must be asked in spite of the fact that the great majority of the incumbents of full time chairs value their academic freedom enormously and see in it the one true path to salvation. Unfortunately, the question still persists, and there are many bits of evidence which raise doubt that the rigid application of the principle of full time medicine justifies its expense.

The reasons are many, but only two need to be mentioned here. Students go to medical school, in the first instance, to be trained in clinical medicine. This means the theory and practice of both the science and the art of medicine. A limited few attend medical school because of the driving interest in the scientific foundations of medicine, and a no less vigorous urge to contribute to them. To make such training effective, every school must have on its staff able men in the practice of medicine and able men in the science of medicine. Fortunately, for mankind, very few individuals combine both these abilities. The great majority do not. Moreover, since most students intend to be physicians, clinical training should be offered by prac-

ticing physicians. Obviously enough, a full time professor in a medical school is not a practicing physician. While it is true that he still sees patients to a limited extent, his very circumstances have cut him off, to a considerable degree, from the manifold problems of the doctor in the community. To be sure, he may know these problems in theory, but his very isolation from them cuts him off from their vital impact. As a result, training in clinical medicine in many schools devolves upon young hopefuls or upon members of the practicing community willing to devote gratuitously varying amounts of time to teaching. Obviously this is not one of the hoped-for consequences of full time medicine. However, it must be said in all fairness that for the one or two per cent of students whose love for science outweighs all other considerations, the full time professor may be, although he not necessarily is, a superior guide. The isolation of the full time university professor in community problems is almost as disastrous as it would be to deprive one of the preclinical professors of his laboratory facilities. Undoubtedly, this was not forseen, but it is a natural consequence of any program which is left to run more or less by itself, and which ignores the supremely important factor of the individuals concerned.

A second unfortunate consequence of full time medicine has, perhaps, been the least anticipated. Designed to prevent the exploitation of the school by the individual, again because of personnel difficulties, the full time program has enabled some individuals to exploit their connection with the institution for their own private benefit. To be sure the benefit, most of the time, is not economic. Rather, more commonly, it is the far more subtle benefit of personnel aggrandizement—kudos, power, freedom from "the slings and arrows of an outrageous fortune."

In many instances, to be sure, fame and fortune are not the consequence of self-interest; but a natural result of the important position the full time professor occupies in the hierarchy of medicine. It is easy enough to argue that the wide ranging activities of many professors, particularly outside the school, redound to the benefit of the school and of medicine; but they always are extraordinarily satisfying to the ego.

It is clear enough from the above that the whole program of full time medicine is an outgrowth of the impact on society of the belief in a higher good than the good of the individual. It is equally clear that this higher good did develop as a consequence of the plan, developed within a medical school of a group of full time professors whose judgment of the nature of the higher good would be final. But like all such formulations, this rests on a spurious foundation. For, in the last analysis, it is the calibre of the individuals who make up the faculty of a medical school that determines its value. Given the right kind of individuals, schemes are not necessary. Instead, they tend to obstruct growth and development. With the right kind of individuals there is no limit to the development of medicine. To discover such individuals is not easy; to train them properly, even more difficult. The solution would seem to rest then, not on schemes, but on more and better training of individuals as physicians, more and better faculties, more and better laboratories. Particularly the faculties should be made up of both high calibre scientists and able practicing physicians. The whole program, necessarily, costs money, but it would be cheap at many times the present price.

SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

Litchfield, Tuesday, October 5

Torrington Country Club, Goshen

Social hour 5:00 P. M. Dinner 6:00 P. M.

Business meeting 7:00 P. M.

(1) Discussion of the Report of the Committee to Study the Organization and Objectives of the Association and the proposed changes of the by-laws

(2) Discussion of the Connecticut Prepaid Medical Care Plan

Fairfield, Wednesday, October 6

Ridgewood Country Club, Danbury

Golf 10:00 A. M. to 4:00 P. M. Business meeting 4:30 P. M.

Social hour 6:00 P. M. Dinner 7:00 P. M.

Guest Speaker: Mr. James E. Bryan, Executive Secretary, New Jersey State Medical Society

Subject: "THE GENERAL PRACTITIONER"

Mr. Bryan is an excellent after dinner speaker. Associated with medical men and societies for many years, though not a medical man himself, he is well qualified to give us the layman's view. His topic should interest us all.

New London, Thursday, October 7

Uncas-on-the-Thames, Norwich

Business meeting 4:30 P. M. Dinner 6:30 P. M. Scientific meeting 8:30 P. M.

Guest Speaker: Roger E. Graves, M.D., Clinical Professor of Urology, Tufts Medical School; Chief of Urology, Carney Hospital; Visiting Urologist, Deaconess Hospital, Boston

Subject: "URINARY OBSTRUCTION FROM THE VIEWPOINT OF THE GENERAL PRACTITIONER"

Middlesex, Thursday, October 14

EDGEWOOD COUNTRY CLUB, CROMWELL

5:00 P. M.

Guest Speaker: Captain Thomas Willmon, U. S. Navy Medical Corps

Subject: "SUBMARINE MEDICINE"

Tolland, Tuesday, October 19

OLD HOMESTEAD INN, SOMERS

6:30 P. M. Dinner

Speaker and subject to be announced

Windham, Thursday, October 21

BEN GROSVENOR INN, POMFRET

6:00 P. M.

Speaker: John C. Leonard, M.D., Clinical Director and Director of Medical Education, Hartford Hospital, Hartford

Subject: "PRACTICAL ASPECTS OF THE TREATMENT OF HYPERTENSION"

Hartford, Tuesday, October 26

NEW ENGLAND HOUSE, BOLTON

Golf 1:00 P. M., Manchester Country Club

Business meeting 5:00 P. M. Dinner 7:00 P. M.

Speaker: William T. Salter, M.D., Professor of Pharmacology, Yale University School of Medicine

Subject: "THE MORBID INTERPLAY OF ENDOCRINES"

New Haven, Thursday, October 28

WATERBURY COUNTRY CLUB, WATERBURY

Business meeting 4:00 P. M. Dinner 6:00 P. M.

Speaker and subject to be announced

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Voluntary Health Insurance or Else

Senator Smith, chairman of the Senate labor and public welfare committee has announced that all bills relating to medical and health matters including compulsory health insurance have been shelved until a special study of such proposals is completed next March 15. This study will be continued through the Congressional recess by a special subcommittee. This means a lull in the tide of battle as far as Congress is concerned but we may be assured that there will be no lessening of effort on the part of those who would curtail the freedom of American medicine. The speech of Dr. Paul R. Hawley before the Conference of Presidents and Other Officers of State Medical Associations on June 20, has already been seized upon by those who are advocating a national health program along the lines of the Wagner-Murray-Dingell bill as an argument for national health planning. This JOURNAL has already commented upon Dr. Hawley's stirring and impressive remarks on that occasion. Much of what he said at that time has important meaning for us, for shortly the physicians of this state are going to be called upon to act decisively upon a voluntary health insurance plan. Dr. Hawley prophetically points out that the future of all voluntary plans depends entirely upon preventing the enactment of national compulsory health insurance legislation for we are going to have one or the other types of prepayment health insurance—not both. He emphasizes also that such legislation can only be prevented if voluntary plans meet every reasonable demand for health insurance. Plans will have to offer more than one type of contract suitable to the desires of those who are willing to pay. Large union groups are demanding a much more comprehensive service than the usual type of contract offered to the low income groups. "This movement," said Dr. Hawley, "has already reached the point where the medical profession has the choice only of making a reasonable effort to meet the requirements of these large consumer groups, or of watching private medicine being rapidly strangled by either cooperative or Government medicine. No other alternatives are left." At the present time we have every confidence that the special committee of our Society is approaching the problem of voluntary health insurance with deep interest and a wide viewpoint. Furthermore we have no criticism of the honesty and concert of effort that has been given to this problem over the years of its study. The time is rapidly approaching, however, when a decision should be reached and a plan put into operation.

Connecticut medicine has always been in the forefront of measures having to do with public health. The adoption of a cooperative plan of prepayment health insurance would be a timely furtherance of that tradition.

Insurance Fundamentals

In view of the broad interest in our prepaid medical care plan and the announcements concerning it which are anticipated in the near future, it is important that the fundamentals of the insurance principle should be known by everyone. Successful voluntary prepayment care plans must follow the basic requirements of insurance. Every physician needs not only to know these requirements, but he will want to make certain that the plan he supports meets this criteria. There are seven such requirements as listed by Dr. Frank G. Dickinson, director, Bureau of Medical Economic Research, American Medical Association and they can be noted in brief.

1. *Laws of Mathematical Probability*—All insurance is based on the ability to predict, with a high degree of accuracy, just how often a certain event may occur. The laws of probability are well developed and will apply to health insurance if the other essential conditions actually are met.

2. *Insurable Interest*—A second requirement of insurance is that the person must stand to lose financially by the occurrence of the event against which he wishes to be insured.

3. *A Large Number of Independent Risks*—A prepaid medical service cannot afford to limit its membership to a group of employees or families working or living so close together that a single epidemic might cause a high percentage of premium payers to require medical service at the same time. There shall be a large number of policy holders scattered over a wide enough area so that it is unlikely that any substantial percentage of persons will demand medical service at any one time.

4. *Importance of the Risk*—Health is important enough to everyone to justify the payment of premiums sufficiently large to provide medical care and to defray the operating cost of the plan.

5. *Uncertainty of Occurrence*—It is not sound to attempt to use insurance to guard against something that is certain to occur. An all inclusive health policy approaches this limitation of certainty. It is almost certain that any given family will need the services of a physician three or four times a year. Any attempt to cover these usual and minor expenses for medical care, then, actually violates this requirement of uncertainty of occurrence.

6. *The Insurance Itself Must Not Immeasurably Increase the Risk*—Will a family which has a health insurance policy make greater demands on its physician than it would make if it did not have such a policy? If the number of such extra calls on a physician is increased to a degree which can be measured and predicted, then it is still possible to determine the probable cost of operation and feasible to issue such policies.

7. *The Risk Must be Measurable*—This is by far the most important requirement of insurance. In health insurance, it means that it must be possible to figure out in advance just how much the total doctor bill for each thousand of insured persons or families is likely to be. The requirement that the risk must be measurable is highly important to the physician who is concerned with the success of prepayment medical care plans. The experience amassed by prepayment medical care plans since 1940 does not cover a sufficiently long period of time or a sufficiently broad section of the population during depression and prosperity to permit us to measure with accuracy the risk that might be involved in the event of serious epidemic or a great depression. The pro rata feature provides that the participating physicians must accept less than their approved fees if the income of the plan for the year is less than the total approved fees. This feature makes the plan secure, for it enables our medical care plans to meet the essential requirements of sound insurance practice *now* without waiting to accumulate broad and detailed actuarial experience.

The Corporative Practice of Medicine

The question as to what constitutes the practice of medicine by a corporation has been controversial for a considerable time. Of great interest, therefore, is the recent opinion from the Attorney General of California as to whether a private non-profit hospital is permitted by law to practice medicine or can legally employ a pathologist on a salary basis. This opinion which may have important and far reaching effects will be found in other pages of this issue. We publish it not only for its immediate interest but also for its value as a ready reference in the light of future expressions of opinion.

THE CANDIDATES SPEAK

Governor Dewey

"Compulsory, socialized medicine is no good. It cannot be done. Accordingly I have spent the last two years of my life knocking down every proposal that anybody has made to regiment the medical profession and the people of America through any program of socialized medicine. By making speeches publicly at every meeting of people that would listen to me on the subject, I have made clear that we have actually been through this thing, this thing which cost the people of my state $200,000 to find out about. I don't want the money wasted. I don't want to run the risk of happening to the health of our people what has happened to the health of every group of people which has tried to drag the medical profession down to the Socialists' level. You won't drag anything up. You will enlarge the volume of medical care but utterly destroy the quality of medical care the minute you try that process.

"Now, some people come to me and say this is just a negative approach, Governor. What do you suggest? Well, my first answer is that if a thing is evil, the first job is to convince people that it is evil and thoroughly evil and destroys everything that we believe in. Then if you have succeeded in doing that, and can get out of their minds that by passing a law you can magically create something which does not now exist, you have made most of the progress. You know, we Americans are the greatest passers of law to solve problems in the world. . . .

"This idea which has been shared by the last two occupants of the White House that you can improve medical care by passing a law must be stopped. We must get vast broad educational ideas to the people, as to the quality of care that now exists and as to a greater program that is going forward by men of medicine, we must have a program all can take a share in. Let's get some good public relations men and get the business man to do his share and get the lawyers and the labor leaders and everybody else. They are the ones who will lose most of all, if freedom in medicine is ever lost. . . .

"Let's get them all understanding and working and they won't want to be putting you in jail with socialized medicine. I am unalterably opposed to it. It won't work and will lower our standard, and I venture our death rate would mount from the very day it was passed. I think there is a positive approach. I don't think the doctors ought to have to handle that approach but you do have to stimulate other people to take part in this job and lead the parade."

President Truman

"The greatest gap in our social security structure is the lack of adequate provision for the nation's health. . . . I have often and strongly urged that this condition demands a national health program. The heart of the program must be a national system of payment for medical care based on well tried insurance principles. . . . Our ultimate aim must be a comprehensive insurance system to protect all our people equally against insecurity and ill health.

"Such a system of (required) prepayment should cover medical, hospital, nursing, and laboratory services. It should also cover dental care—as fully and for as many of the population as the available professional personnel and the financial resources of the system permit. The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund, instead of paying sporadically and unevenly while they are sick. This health fund should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to secure adequate financial support for doctors and hospitals everywhere. If we were to rely on state-by-state action only, many years would elapse before we had any general coverage . . .

"I am in favor of the broadest possible coverage for this insurance system. I believe that all persons that work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, and employees of nonprofit instituitons and their families. In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies."

PROGRESS IN CLINICAL MEDICINE

THE TREATMENT OF AMEBIASIS

SYDNEY SELESNICK, M.D., *Newington*

The Author. *Staff Gastroenterologist and Assistant to the Chief, Medical Service, Veterans Administration Hospital, Newington, Connecticut; Clinical Instructor in Medicine, Yale University School of Medicine*

INTRODUCTION

Amebiasis is a general term designating infection by Endameba histolytica. It includes all clinical manifestations of the disease as well as the asymptomatic carrier state. Amebic enteritis and amebic hepatitis are the commonest clinical forms. Involvement of the lungs, brain, skin, genito-urinary tract and other organs occurs but is relatively rare.

Amebiasis has been endemic in Connecticut for many years. In 1923 Blake and Hiscock reported nine cases in Ansonia.[1] In 1934 Foster noted that during the preceding 10 years over 30 cases of amebiasis, with 15 deaths, had been reported to the State Department of Health in Connecticut.[2] He also discussed 8 cases seen in his own practice during a 4 year period. During the years 1940-1944, 20 cases were reported to the State Health Department.[3] Since the end of World War II large numbers of infected servicemen have returned home. From July 1946 to December 1947, 30 patients have been treated for clinical amebiasis at the Veterans Hospital, Newington, Connecticut. How serious a future public health problem the infected veterans will create is unknown. That they do represent a possible hazard is known to the author. Two months after the return home of a Connecticut soldier his father developed a bloody diarrhea eventually shown to be caused by Endameba histolytica. Investigation proved the son to be an asymptomatic cyst-passer.

There are several drugs capable of eliminating most infections with Endameba histolytica if properly employed. Therefore it behooves every practicing physician to know the many varied expressions of the disease, for it frequently does not lend itself to ready suspicion and diagnosis. Many excellent reports describing the clinical aspects of the disease are available.[4-8]

DRUGS USED IN THE TREATMENT OF AMEBIASIS

A wide variety of drugs has been used to treat amebiasis. Only five have retained their popularity in this country because of their therapeutic effectiveness and relative safety when properly used. These five are emetine hydrochloride, carbarsone, chiniofon, vioform and diodoquin. No single one will cure all cases of amebiasis, but if used in appropriate combination or sequence a very high percentage of cures can be expected. There are occasional cases of amebiasis that do not respond to any known drug.

Emetine is an alkaloid derived from ipecacuanha, the dried root of Psychotria ipecacuanha. It is a protoplasmic poison, acting directly on the trophozoite of Endameba histolytica. The drug is given subcutaneously or intramuscularly as emetine hydrochloride. There is frequently a local reaction at the site of injection which is less painful when the subcutaneous route is used. Because of its toxicity emetine should never be given intravenously. Toxic symptoms are not uncommon following use of the drug because of its cumulative effect. The symptoms and signs of toxicity usually observed are anorexia, nausea, vomiting, diarrhea, tachycardia, cardiac arrhythmias, low blood pressure, pulmonary edema, cardiac failure, faintness, general lassitude, muscular

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tremors, muscle pain, and also albuminuria, purpuric skin rashes, urticaria and cerebral edema.

There has been a tremendous experience with emetine during the past few years. It is now known that with proper vigilance and care dangerous reactions need not be feared. The daily adult dose should not exceed 0.065 gram (one grain). A course of treatment should not exceed 12 daily doses. It is advisable to interrupt the course by a 3 day rest period after the sixth or ninth day. Klatskin believes that a course of emetine may be repeated, if necessary, after a two-week rest period if proper attention is given to dosage and toxic signs.[4] Dock and Moloshok, however, point out that electrocardiographic signs of toxicity may not appear until 1 to 2 weeks after the drug has been stopped.[9] They feel that a month should intervene between courses. Children should probably not be given emetine unless all other drugs have failed and amebic infection endangers their life. Craig states that children 8 years of age should be given not more than 0.02 gram (⅓ grain) daily, and younger children not more than 0.01 gram (⅙ grain) daily.[8]

The greatest care must be exercised to detect symptoms or signs of toxicity. If any appear the drug should be immediately discontinued. Toxic manifestations have appeared after the third or fourth dose. Since the chief toxic effects of emetine are on cardiac and striated muscle the following precautions especially should be taken during the period of treatment: Absolute bed-rest; pulse and blood pressure observations at least twice daily; inquire daily about diarrhea, fatigue, dyspnoea, muscular tremors and pains, and dizziness; if possible obtain electrocardiograms before treatment, after the fifth dose, at the end of treatment, and 1 and 4 weeks later for signs of cardiac injury; keep the patient in bed until at least 2 days after completion of emetine treatment; do not give emetine to patients with known heart disease.[9]

Emetine given parenterally acts chiefly on trophozoites buried in the tissues but not on those, or the encysted form, in the lumen of the colon. Used alone it will produce only a low incidence of cures in colonic amebiasis. When used together with the iodine or arsenical amebicides it results in a very high percentage of clinical cures. Its greatest usefulness is in treating the extra-colonic complications, especially amebic hepatitis and hepatic abscess.

Of the arsenical amebicides carbarsone (4-carbaminophenyl-arsonic acid) is the least toxic and most effective. It has superceded the more toxic acetarsone and treparsol. Carbarsone is given in 0.25 gram (4 grain) doses, 2 or 3 times daily for 10 days. The course may be repeated, if necessary, after a 10 day rest period. When used as a retention enema in refractory cases, 1 per cent carbarsone in 200 c.c. of a 2 per cent sodium bicarbonate solution is used. The toxicity of carbarsone is related to its arsenic content. In the dosage given above toxicity is rarely encountered. In persons with amebic hepatitis it is probably better not to use carbarsone until after a course of emetine has been successfully completed. As with other arsenicals it should be given with caution to patients having liver or kidney disease.

Chiniofon, vioform, and diodoquin have proven to be safe and effective amebicidal iodine compounds. They are reputed to result in a high percentage of cures, though opinion in this regard is not unanimous.[10] Of the 3 diodoquin probably has the greatest popularity today because of the rarity of toxicity and the absence of undesirable side reactions.

Chiniofon is 1—iodo-8-hydroxyquinolin-5 sulphonic acid, 4 parts, and 1 part sodium bicarbonate, the whole containing not less than 28.5 per cent iodine. When used orally or rectally in the dosage to be described it is not known to have produced an untoward reaction. It has, however, one side reaction, diarrhea, which has turned many to the newer iodine amebicides. The diarrhea, when it occurs, lasts for only 2 or 3 days and is not usually exhausting, though it may be so. It ceases when the drug is stopped and is not known to have caused any permanent sequellae. Chiniofon is prescribed as a pill or tablet, each containing 0.25 gram (4 grains). Three such tablets, 3 times daily for 10 days is the usual course of treatment. The course may be repeated, if necessary, after a 10 day rest period. If diarrhea occurs during administration of the drug the dosage may be reduced or the drug discontinued, depending on the severity of the diarrhea. In refractory cases chiniofon may be used as a retention enema, 200 c.c. of a 2 per cent solution in warm water to be retained for several hours. The enema is given once daily for eight to ten days.

Vioform contains not less than 37.5 per cent and not more than 41.5 per cent iodine. It is an efficient amebicide. It hasn't enjoyed the popularity of chiniofon or diodoquin because of occasionally reported toxic reactions. Lewis recently reported excellent results with this drug.[11] He found vioform most con-

venient for retention enemas in refractory cases and those with rectal lesions. He gives a 1 per cent suspension of vioform in 200 c.c. tap water on alternate nights for 5 doses. Lewis prefers vioform orally to chiniofon or carbarsone because it doesn't produce diarrhea medicamentosa. It is taken orally in capsules, in 0.25 gram (4 grains) doses 3 or 4 times daily for 10 days; after a 10 day rest period the initial course is repeated. A full course is given, therefore, over a period of 30 days.

Because of its very low toxicity and absence of undesirable side reactions diodoquin is at present riding the crest of popularity among the iodine containing amebicides. It is administered as a tablet containing 0.21 gram (3.2 grains). Three tablets taken 3 times daily for 20 days constitutes a course of treatment. D'Antoni recommends that children aged 6-12 years receive two-thirds the adult dose daily.[12] He reports a very high incidence of cures with one course of treatment in acute or chronic amebic dysentery.

There are two other preparations that deserve mention. Emetine-bismuth-iodide is used extensively by British physicians in the treatment of amebiasis. Because of its potential toxicity and severe side-reactions the drug has never gained wide acceptance in this country. Recently Shrapnel, Johnson and Sandground reported their results using enteric-coated tablets of emetine hydrochloride.[13] They obtained encouraging results without evidence of the toxic reactions which may occur with parenteral administration of the drug. There has been no extensive clinical experience with this enteric-coated preparation.

THE TREATMENT OF AMEBIASIS

The treatment of amebiasis will be discussed under four headings: (1) symptomatic amebiasis of the colon, (2) amebic hepatitis and hepatic abscess, (3) the asymptomatic carrier state, (4) other types of amebiasis.

(1) Symptomatic amebiasis of the colon. Under this heading is included all of the colonic manifestations of amebiasis, from those that are mild and vague to ameboma and severe amebic dysentery. The trophozoite of Endameba histolytica produces a cytolytic toxin that dissolves the mucosal cells. Being actively motile it is capable of deep penetration of tissues. One cannot assume, because symptoms are mild, that deep tissue penetration has not already taken place. Indeed, the incidence of hepatic complications in persons with very meagre colonic symptoms is unusually high.[5] Therefore in every case of symptomatic amebiasis of the colon treatment should be thorough and complete if it is to effect a cure in the greatest number of patients.

Independent investigators have claimed a high percentage of cures with all of the drugs described above when used individually and in combination. The most successful treatment programs seem to be those combining emetine hydrochloride with either carbarsone or one of the iodine compounds. The emetine hydrochloride is given intramuscularly or subcutaneously in doses of 0.065 gram (1 grain) daily for 6 to 9 days. Emetine rapidly brings the diarrhea under control. If this is accomplished with 6 doses of the drug it need not be continued further. Diarrhea that reappears after having been initially controlled may be interpreted as a sign of emetine toxicity. If diarrhea persists throughout the period of emetine therapy, secondary bacterial infection should be suspected. If it can be demonstrated by microscopic study of the stool one of the sulfonamides should be given. In no event should more than nine consecutive doses of emetine hydrochloride be given. Concurrent with or after completion of the course of emetine one of the other amebicides is given, in dosages already described. The treatment program used by the author is as follows: emetine hydrochloride 0.065 gram (1 grain) daily is given subcutaneously for 6 days. This is followed by a course of carbarsone 0.25 gram (4 grains) 2 or 3 times daily for 8 days. Concurrent with the emetine and carbarsone the patient is given diodoquin 0.63 gram (9.6 grains) 3 times daily. If, between the tenth to fourteenth days, the stools are negative and the patient asymptomatic he is discharged with instructions to continue diodoquin for 1 more week. If the stools remain positive: the diodoquin is continued for a third week; emetine is resumed until a total of 12 grains (including the initial course) has been given; nightly retention enemas of carbarsone, chiniofon or vioform are given. The patient is prepared for the retention enema with a preliminary cleansing enema of warm water, and a sedative. If the stools still remain positive full courses of arsenical and iodine amebicides are alternated until the stools become negative.

AMEBIC HEPATITIS AND ABSCESS

The amebae reach the liver through the portal circulation. Their cytolytic toxin destroys liver cells and an inflammatory reaction is initiated producing a diffuse hepatitis. If this process continues long enough abscess results.[14]

Emetine is the drug par excellence for amebic hepatitis. Twelve daily doses of 0.065 gram (1 grain) for a total of 0.78 gram (twelve grains) are given. A 3 day rest period after the sixth or ninth dose is allowed. Concurrently an iodine containing amebicide is given by mouth. Carbarsone, if used, should not be given until the course of emetine has been completed. Albright and Gordon, however, encountered no intolerance to carbarsone in patients with infectious hepatitis.[5]

Of 69 patients with hepatic amebiasis Klatskin cured 68.[15] His treatment consisted of twelve grains of emetine hydrochloride over a 15 day period as described above. After a 2 week rest period courses of 6 grains each of emetine were given alternated with 2 week rest periods until the criteria of cure were met. These consisted of: Complete absence of pain and fever; absence of liver enlargement; absence of subcostal and compression tenderness; and normal leukocyte count and sedimentation rate. He supplemented the emetine with alternating courses of diodoquin and carbarsone to eradicate associated intestinal amebiasis. Klatskin feels that though the toxicity of emetine warrants a healthy respect, the dangers attending its use have been exaggerated.

Early acute amebic abscesses of the liver may be cured with emetine alone. Larger doses are usually required than for amebic hepatitis. Though cures of chronic amebic abscesses have been reported using large doses of emetine, aspiration is usually required. Failure of the patient to improve after 12 grains of emetine is the indication for aspiration. Emetine and closed aspiration have eliminated the necessity of open surgical drainage. The procedure is to give the patient a course of 0.78 grams (12 grains) of emetine hydrochloride. Following this the abscess is drained by aspiration. Before the needle is removed 100,000 units of penicillin are instilled into the cavity. A second or third aspiration may be necessary. An oral amebicide is also used. The regular emetine precautions should be observed. Heretofore, secondarily infected abscesses were treated by open drainage.[16] It is anticipated that the use of penicillin and the sulfonamides may make this unnecessary.[17]

THE ASYMPTOMATIC CARRIER STATE

It is currently believed that asymptomatic cyst-passers are not living in harmony with the parasite. Non-pathogenic, avirulent strains of Endameba histolytica are unknown. About one-third of those developing hepatitis give no history of diarrhea or dysentery. The absence of symptoms is, therefore, no index of the extent of tissue invasion. It must be assumed that the carrier state is an active stage of the disease and deserves effective treatment. Furthermore, the carrier represents the large human reservoir from which clinical amebiasis is acquired. Control of this reservoir is essential in the interests of the public health. The carrier should receive a short course (6 grains) of emetine in conjunction with an oral amebicide. However, since the carrier is not ill it is difficult to put him to bed for emetine therapy. It is accepted practice, therefore, to give the carrier an oral amebicide that will not inconvenience him or interfere with his normal activities. A full course of diodoquin fulfills this purpose and is reported to give a high percentage of cures. Similar good results are reported with chiniofon, vioform, and carbarsone. They should be reserved for those instances where diodoquin fails to produce a cure.

OTHER TYPES OF AMEBIASIS

Langston and Fox recently reported 10 cases of pleuropulmonary amebiasis all complicating hepatic amebic abscess.[18] Treatment consisted of emetine hydrochloride and an oral amebicide. The chest was aspirated when necessary to relieve pressure symptoms. They state that surgical drainage is not indicated and may even delay recovery. Of the 65 cases of amebic brain abscess reported in the literature in only five did the cerebral involvement occur without liver abscesses or other evidence of amebiasis.[19] Cerebral amebic abscess is usually fulminating, death occurring within a few days after onset of clinical symptoms. When abdominal surgery is contemplated on patients with suspected amebiasis, antiamebic treatment should be started beforehand to avoid possible complications. If amebiasis is not recognized until the time of surgery, treatment should be started at once.[4] Cutaneous amebiasis may complicate colostomy, draining liver abscess, and perianal, perineal, and other wounds in persons with amebiasis.[8] The skin lesion is very painful and destructive. It responds well to antiamebic therapy. Amebiasis of the penis, urethra, epididymis and bladder have been reported; also rupture of hepatic abscesses into the peritoneal cavity, stomach, gall bladder and biliary ducts, pericardium and vena cava. These complications are rare.

The patient treated for amebiasis is not cured until the stools are persistently negative after completion

of treatment. Because therapy may inhibit the appearance of cysts in the stool, specimens should be checked once monthly for three months at least. A watery stool after a saline purge is best for finding trophozoites, if any are present. It should be remembered that some persons, after being cured of amebiasis, may be left with a functionally irritable colon that may require a special diet or psychotherapy.

BIBLIOGRAPHY

1. Blake, F. G., and Hiscock, I. V.: Amebic Dysentery in Connecticut. Proc. of Conn. State Med. Soc. p. 125, 1923.

2. Foster, J. H.: Amebiasis in Connecticut. New Eng. J. Med. 210:294-299, 1934.

3. State of Connecticut, Sixtieth Report of the State Department of Health, Hartford, Connecticut, 1945.

4. Klatskin, Gerald: Observations on Amebiasis in American Troops Stationed in India. Ann. Int. Med. 25:773-788, 1946.

5. Albright, E. C., and Gordon, E. S.: Present Status of the Problem of Amebiasis. Arch. Int. Med. 79:253-271, 1947.

6. Elsom, K. A., Rogers, A. M., and Wood, F. C.: Amebiasis: Observations in an Army General Hospital in India. Gastroenterology 8:135-153, 1947.

7. Nicholson, J. H., and DeDominicis, F. A.: Amebiasis. New Eng. J. Med. 237-799-805, 1947.

8. Craig, C. F.: The Etiology, Diagnosis, and Treatment of Amebiasis. The Williams and Wilkins Co., Baltimore, 1944, 332 pp.

9. Dock, S., and Moloshok, R. E.: Cardiac Manifestations of Toxic Action of Emetine Hydrochloride in Amebic Dysentery. Arch. Int. Med. 79:228-238, 1947.

10. Karl, M. M., and Sloan, F. R.: The Management of Amebiasis. Ann. Int. Med. 25:789-798, 1946.

11. Lewis, R. A.: Enteric Infections and their Sequellae. New Eng. J. Med. 235:571-581, 1946.

12. D'Antoni, J. S.: Further Observations on Amebic and Bacillary Colitis in the New Orleans Area. Am. J. Trop. Med. 23:237-242, 1943.

13. Shrapnel, B. C., Johnson, C. M., and Sandground, J. H.: Oral Emetine in the Treatment of Intestinal Amebiasis. A Preliminary Report. Am. J. Trop. Med. 26:293-310, 1946; Shrapnel, B. C.: Oral Emetine in the Treatment of Intestinal Amebiasis. Am. J. Trop. Med. 27:527-544, 1947.

14. Warshawsky, H., Nolan, D. E., and Abramson, W.: Hepatic Complications of Amebiasis. New Eng. J. Med. 235:678-681, 1946.

15. Klatskin, G. K.: Amebiasis of the Liver: Classification, diagnosis, and treatment. Ann. Int. Med. 25:601-631, 1946.

16. Ferguson, L. K., and Anderson, R. K.: Amebic Liver Abscess in Service Personnel. Gastroenterology 8:332-343, 1947.

17. Noth, P. H., and Hirshfeld, J. W.: Amebic abscess of the Liver with Secondary Infection: Local Treatment with Penicillin. J.A.M.A. 124:643-646, 1944.

18. Langston, H. T., and Fox, R. T.: Pleuropulmonary Complications of Amebiasis. Arch. Surg. 55:618-623, 1947.

19. Chalgren, W. S., and Baker, A. B.: The Nervous System in Tropical Disease. A Clinical Review. Medicine 26: 395-440, 1947.

PRACTICE OF MEDICINE BY PRIVATE NONPROFIT HOSPITALS HELD ILLEGAL

Recently, the State Board of Medical Examiners requested the opinion of Fred N. Howser, Attorney General of California, as to whether a private nonprofit hospital is permitted by law to practice medicine, and, if not, as to whether such a hospital could legally employ a pathologist on a salary basis.

On May 19, 1948 the Attorney General rendered an opinion to the State Board of Medical Examiners, holding, first, that a private nonprofit hospital may not practice medicine, and, second, that the employ ment on a salary basis of a pathologist by such a hospital would constitute the unlawful practice of medicine by the hospital.

The opinion, in full, follows:

OPINION of
Fred N. Howser, Attorney General
E. G. Funke, Deputy Attorney General

The Board of Medical Examiners has submitted the following questions:

1. Is a corporation or an association of laymen operating a private, nonprofit hospital permitted to practice any system or mode of treating the sick or afflicted in this State?

2. If a corporatoin operating a private, nonprofit hospital enters into a contract with a physician under which the physician will perform professional services in the hospital and receive a fixed salary, and

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he corporation will thereupon bill the patient for he professional services rendered by the physician t rates that have no bearing on the physician's sal-ry, is the corporation violating any of the pro-isions of the Medical Practice Act?

The conclusions reached are summarized as fol-ows:

1. No one is permitted to practice any system or node of treating the sick or afflicted in this State unless he is licensed in accordance with the provi-sions of section 2000 et seq., Business and Profes-sions Code. Corporations or other artificial legal en-tities are specifically mentioned in section 2008 as having no professional rights, privileges or powers, and may therefore not be licensed to so practice.

2. The employment of a licensed physician by a corporation and the subsequent billing of the patients by the corporation, as referred to in the second question, would constitute illegal practice of a system or mode of treating the sick or afflicted in this State and is therefore prohibited by law.

ANALYSIS

The Board of Medical Examiners advises that a private, nonprofit hospital operating in the State and owned by a corporation, contemplates entering into a contract with a duly licensed physician and surgeon who specializes as a pathologist. They propose that the physician and surgeon will perform professional services for hospital patients and receive therefor a fixed salary. The corporate owner of the hospital proposes to separately bill each private patient for the professional services that have been rendered to such private patient by the pathologist. They propose that such charges are to be independent of the ordinary regular charge for hospital bed, board and usual hospital services and further, that the rate of charge will have no bearing on the salary that the pathologist will receive from the corporation.

The courts have made it abundantly clear, as is hereafter shown, that corporations are prohibited from engaging in the practice of any system or mode of treating the sick or afflicted in this State. The pronouncements of the courts also, in our opinion, require the conclusion that the arrangement contemplated by the hospital in question falls within the same prohibition.

The California Legislature has enacted a Corporations Code. In the Corporations Code there are found various provisions governing the formation, powers and duties of corporations as a whole. Since a corporation is a "creature created by statute," it has only such powers as the statutes give to it. Nowhere in the Corporations Code is a corporation given specific authority to practice the healing arts.

We must, of course, call attention to the fact that certain nonprofit corporations may be formed for the purpose of defraying or assuming the cost of professional services of licentiates of the healing arts. Section 9201, Corporations Code, formerly Section 593(a) Civil Code, so provides. However, the same section except as expressly permitted therein does not authorize the formation of any corporation for the purpose of rendering the professional services regulated by Division 2 of the Business and Professions Code. Likewise, Chapter 1 of Division 2 of the Health and Safety Code, governing the operation of clinics and hospitals, specifically provides (section 1214) that the provisions of said chapter do not authorize any person other than a licentiate of a healing art to engage *directly or indirectly* in the practice of medicine.

The opinion of the Supreme Court in California Physicians' Service v. Garrison, 28 Cal. (2d) 790, construed the provisions of Corporations Code 9201, formerly Civil Code 593(a), and particularly the authorizing of the incorporation of a physicians' service. The court therein states (page 802): "the Legislature, by enacting section 593(a) of the Civil Code, expressly authorized the organization of corporations such as California Physicians' Service. By this enactment *the state's social policy in regard to the corporate practice of medicine, to the limited extent specified, has been determined* and the courts are bound thereby. [Emphasis added.]

Further, a corporation, although considered by law as a legal entity, and to have in many respects all the rights and privileges of an individual person, nevertheless is physically unable to fulfill the educational requirements or to take the examination required of all persons who seek to secure a license to practice the healing arts. Thus, even though section 2008, Business and Professions Code, did not specifically state that a corporation has no professional standing, nevertheless it would be a physical impossibility for a corporation to be a licentiate of a healing art.

Our courts have on numerous occasions held that a corporation may not engage in the practice of medicine. The opinion of the Supreme Court in Pacific Employers Insurance Co. v. Carpenter, 10

Cal. App. (2d), 592, 594, contains a comprehensive discussion which is pertinent. The following quotation summarizes the court's views on this subject:

"It is well settled that neither a *corporation nor any other unlicensed person or entity may engage, directly or indirectly*, in the practice of certain learned professions including the legal, medical and dental professions. [Cases cited.] Under the foregoing authorities it is clearly declared unlawful for a corporation to indirectly practice any of said professions for profit by engaging professional men to perform professional services for those with whom the corporation contracts to furnish such services. In other words, said authorities declare that said professions are not open to commercial exploitation as it is said to be against public policy to permit a 'middleman' to intervene for profit in establishing the professional relationships between the members of said professions and the members of the public." [Emphasis added.]

In People v. Pacific Health Corporation, 12 Cal. (2d), 156, 158, the court stated that: "It is an established doctrine that a corporation may not engage in the practice of such professions as law, medicine or dentistry." [citing cases.] The appellant, Pacific Health Corporation, contended, however, that it did not itself undertake to perform medical services, but merely to furnish competent physicians; that the physicians and surgeons were not to be employed by it on a salary basis, nor directed by it, but were to be compensated for actual professional services after they were rendered; and the corporation's theory was that the doctors, under its arrangement, were to be independent contractors and that, therefore, the corporation would be absolved of the charge of practicing medicine. The court said:

"We are unable to agree that the policy of the law may be circumvented by technical distinctions in the manner in which the doctors are engaged, designated or compensated by the corporation. The evils of divided loyalty and impaired confidence would seem to be equally present whether the doctor received benefits from the corporation in the form of salary or fees. Any freedom of choice is destroyed, and the elements of solicitation of medical business and lay control of the profession are present whenever the corporation seeks such business from the general public and turns it over to a special group of doctors."

This argument that the mere ownership of a hospital where medical services are rendered by the owners' licensed employees does not in itself constitute the practice of medicine (i.e., that the practice of medicine involves actual treatment of persons) was also rejected by our courts when applied to the practice of dentistry. See Painless Parker v. Board of Dental Examiners, 216 Cal. 285, 296. Appellant in that case contended that there was a distinction between the practice of dentistry which the statutes undertook to regulate, and the purely business side of the practice and that the management and conduct of the business side by a layman was not prohibited by the statute, and that such attempted prohibition would be unconstitutional. We refer to the well considered opinion of the court, wherein are given the reasons for the rejection of this contention made by appellant.

It may be contended that the pathologist in the situation presented would merely examine and diagnose an illness and therefore would not be practicing medicine. But our courts have held that diagnosis is as much a part of the practice of medicine as is the administration of remedies. In fact, section 2141, Business and Professions Code, declares that one who diagnoses any illness is engaging in the practice of medicine (see People v. Jordan, 172 Cal. 391).

Throughout the opinions cited one will note that the courts have indicated that the practice of medicine by corporations for profit, through the employment of licensed physicians, has a tendency to debase the profession, is not in the interests of the safety, health and welfare of the public, and therefore is contrary to public policy. The right to practice medicine and surgery under a license by the State is a personal privilege. It cannot be delegated. Therefore, a corporation or other unlicensed person may not engage in the practice of medicine by employing one who is licensed is do the things which constitute the practice of the profession. Were the rule otherwise, one would find a licensed physician accepting directions and instructions in the diagnosing and treating of ailments from a corporation or from an individual who is not a licensed practitioner.

THE PRESIDENT'S PAGE

The good physician is perforce an humanist in that he is by nature or becomes so by experience, intimately familiar with many personalities, no two of which are identical. He is, therefore, keenly conscious that his patients are individuals and that he is one likewise. To him it seems unnatural to think of them and of himself as relatively insignificant units submerged in a flood of data and he unconsciously shrinks from the conception of a person as a "statistic."

Yet, all individuals have many things in common and the more intimately they are associated the one with the other, the greater is the number of these. Anyone in our present civilization is dependent in one way or another upon an infinite number of others. Group activity is a necessity, at the family level, in various societal and professional organizations and now it is apparent in the larger areas of national and international interest. For the understanding of these relationships and for their improvement it is imperative that pertinent data be assembled, scientifically analyzed and utilized wherever possible, else this topsy-turvy world of ours, by reason of its complexity and our lack of understanding of it, may come tumbling down about our ears. For these purposes, each individual, whether he likes it or not, is a datum.

Moreover, he is caught in a dilemma which forces him to act in concert with others while at the same time attempting to preserve his individuality. The extremes of this are absolute subservience to dictatorial authority on the one hand or complete anarchy on the other; the ultimate result in either instance being the disintegration of the present advanced stage of our societal development.

Somewhere in between, a compromise must be effected which while not satisfying the complete individualist nor meeting the dictates of the authoritarian does provide for the great majority as much of security as is possible against the hazards, whether catastrophic or otherwise, of war, starvation and disease, at the same time interfering as little as possible with freedom of thought and action, and providing the greatest possible opportunity for individual development. This may seem trite and axiomatic and indeed would have been not too long ago, but today it is apparent that concerted, integrated and positive action is urgently necessary to make these postulates work, else the Dark Ages will again supervene. In this the physician, as a citizen as well as by reason of his professional attributes, has a heavy responsibility.

Samuel C. Harvey, M.D.

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BUILDING PLANS DEVELOP

Encouraging progress with plans for the headquarters building for the Society have been made in t past month. Revised architect's drawings which meet the needs of the Society have been approved a working specifications have been let out for bids from contractors. Although the estimated cost of t building now contemplated is substantially lower than the first figures quoted, more funds are still need and it is hoped that members who have not contributed will do so as soon as possible.

Prepaid Medical Service Plan

The Committee on Prepaid Medical Service under the chairmanship of Dr. Thomas J. Danaher continues to work diligently on the development of a service-indemnity prepayment plan to be sponsored by the Society. The Council has approved the Joint Statement of Principles involved in such a plan, previously approved by the sub-committee representing the State Society and Connecticut Hospital Service, Inc. A schedule of indemnities has been drawn up and submitted to actuaries for computation of premium rates, and a Subscriber's Contract and Participating Physicians agreement are now in the process of completion. It is planned that detailed reports on the Plan will be given at the semi-annual meetings of the county associations.

State-Wide Blood Bank

Representatives of the Society's State-Wide Blood Bank, the American Red Cross, Hartford and Grace-New Haven Community Hospitals and Yale Medical School have interviewed a candidate for medical dircetor of the proposed blood bank, although this candidate has not yet been employed because of necessary financial rearrangements. It is hoped that he will begin his duties in the near future.

New Conference Committee

A new committee authorized by the House of Delegates at the Annual Meeting in April has now been appointed. This committee consists of the following members:

Connecticut State Medical Society:
Katherine J. Edgar, Bridgeport
Joseph A. Fiorito, New Haven
D. Dillon Reidy, Hartford

Connecticut State Nurses' Association:
Miss Irma Biehusen, New Haven
Mrs. Helen M. Cullen, Hartford
Miss Agnes Ohlson, Hartford

Connecticut Hospital Association:
William J. Donnelly, Greenwich
Leon H. French
Richard J. Hancock, New London
Hiram Sibley, New Haven

Cancer Education Program

The Sub-Committee on Professional Education the Society's Committee on Tumor Study has sent letter to each local medical and dental association the state offering to assist in the arrangement of cancer program and to provide speakers during t coming year. Already there have been several a ceptances of this offer.

Uniform Schedule of Fees for State Patien

Beginning October 1 all physicians treating Sta patients will be paid according to a uniform f schedule. This schedule was drawn up by a cor mittee appointed by State Commissioner of Finan and Control, James B. Lowell, in November 1947 consultation with the State Medical Society.

The committee's report states that the fees set will e somewhat lower than those paid by patients of verage means and will be the same for all State gencies.

New Diagnostic Clinic at Yale

The faculty of the Yale University School of Medicine wishes to announce the opening of a Diagnostic Clinic on October 1, 1948.

The clinic is prepared to provide diagnostic consultation services for private patients referred by heir physicians. The clinic will be staffed by members of the Departments of Medicine, Obstetrics and Gynecology, Psychiatry, and Surgery. The examination of an ambulatory patient will require a period of one to three days, and perhaps longer for occasional cases. For those patients residing in or near New Haven, there may be short intervals between each visit. For those residing at some distance from New Haven, the diagnostic study will be continuous, and it will be necessary to make reservations at one of the New Haven hotels or with private families. The patients who are considered too ill to be cared for in this way will of necessity be admitted to the Grace-New Haven Community Hospital, New Haven Unit, at the earliest opportunity.

The overall fees for this service will be related to he extent of the diagnostic work up, but the maximum charge will not exceed $150.

An effort will be made to provide prompt service nd to have a written or verbal report in the hands f the referring physician within a day or two of he patient's discharge.

Arrangements for therapy as recommended will emain the responsibility of the referring physician.

Information pertaining to the clinic may be obained, and appointments may be made, by addressng the Yale Diagnostic Clinic, 789 Howard Avenue, New Haven, Connecticut; or by telephoning New Haven 5-1161, extension 382.

Dr. Bartlett Retires from Grace Hospital

The retirement of Dr. Charles J. Bartlett, chief pathologist at New Haven's Grace Hospital for more than 30 years, was announced recently.

Actively engaged in medical practice for more than half a century, Dr. Bartlett received his medical degree at the Yale University School of Medicine in 1895. Following a period of postgraduate study in Leipzig, Germany, he returned to New Haven to accept appointment in 1897 as assistant professor of pathology at Yale University. From 1900 to 1917 he was professor of pathology, and also pathologist and attending physician on the staff of the New Haven Hospital.

In 1918 he left the university to assume duties as pathologist at the Grace Hospital, and later accepted additional appointments as consulting pathologist at the Charlotte Hungerford Hospital, Torrington, and the Griffin Hospital, Derby. He was appointed a member of the New Haven Board of Health in 1912, and was responsible for enactment of the original ordinances to safeguard the city's milk supply.

Dr. Bartlett was formerly president of the Connecticut Medical Examining Board, and his membership on the board was continuous for more than 20 years. He is a former president of the New Haven County Medical Association, and in 1918 he served as president of the State Medical Society.

He will continue to hold his position as consulting pathologist at the Griffin Hospital. Professional associations of which he is a member include the American College of Surgeons, American Board of Pathology, American Association of Pathologists and Bacteriologists, New York Pathological Society, and the American Public Health Association.

Dr. Levin L. Waters Succeeds Dr. Bartlett

Dr. Levin L. Waters, assistant professor of pathology at the Yale School of Medicine, has been appointed pathologist of the Grace Unit of the Grace-New Haven Community Hospital, effective September 1. Dr. Waters succeeds Dr. Charles J. Bartlett.

At the same time it was announced that Dr. Waters would be chairman of a newly formed committee to coordinate and plan the development of the service laboratories of both units. An improvement in both the speed and quality of service to patients is the objective.

Dr. Waters, like his predecessor, is both a graduate and a member of the faculty of the Yale School of Medicine. He received his A.B. degree, cum laude, from Princeton in 1932 and spent the next year as an inspector of foods and drugs in the Maryland State Department of Health. He entered the

Yale School of Medicine in 1933 and received his M.D. here in 1937 when he was appointed intern in pathology at the New Haven Hospital.

The next year he received the Charles Linnaeus Ives Fellowship in Pathology and was appointed assistant resident of that service, becoming resident in 1939, and an instructor in the Medical School. In 1940 he became International Cancer Research Foundation Fellow in Pathology at the Memorial Hospital in New York, working under the direction of Drs. James Ewing and F. W. Stewart.

During the war years 1941 to 1945 he was technical aide with the Committee on Medical Research of the Office of Scientific Research and Development, and also technical aide with the Division of Medical Sciences of the National Research Council, spending the last year of this overseas in the service of these agencies.

In 1943, while still on leave of absence from the medical school doing war work, he was appointed assistant professor of pathology of the Yale School of Medicine and also received his appointment as associate pathologist of Grace-New Haven Community Hospital.

Dr. Waters' faculty status at Yale will be unchanged by the new appointment.

Dr. Sinclair Appointed to State Department of Health

Dr. Edward B. Sinclair of New Haven has been appointed Crippled Children physician in the State Department of Health.

Dr. Sinclair is a native of New Haven. He was graduated from Brown University in 1933 and received his medical degree from the Yale University School of Medicine in 1935. He interned for two years at the Rhode Island Hospital, Providence, R. I., and later was pediatric resident at St. Luke's Hospital, New York City. He served as pediatric resident at the Massachusetts General Hospital and joined the Army Medical Corps in 1940. He served in the African and European theaters, mainly with the 7th Infantry Regiment, and was discharged with the rank of lieutenant colonel in 1946.

After his discharge from the Army, Dr. Sinclair was medical consultant for vocational rehabilitation at the Veterans' Administration office at Providence for about a year. He attended the Yale School of Public Health this year. He started his duties with the State Health Department September 1.

Horace Wells Memorial Volume

The Horace Wells Memorial Volume of 500 pages will be ready for sale and distribution some time in October 1948.

The editor is Dr. William J. Gies, M.S., PH.D., SC.D. L.L.D., F.A.C.D., of Columbia University.

The volume presents the "Proceedings of centenary commemorations of Wells' discovery in 184. and lists of Wells memorabilia, including bibliographies, memorials and testimonials."

The Introduction is the outcome of a thorough study, by the editor, of the records of the "anesthesia controversy." It shows by elimination o irrelevant and misleading personal and emotiona details that have beclouded the "anesthesia story" true and unbiased picture of the great discovery.

Successive sections contain complete and detailed accounts—all from local authoritative sources—o the 500 Wells Centenary commemorations in England, France, fourteen nations in Central and South America, and in the states in the United States; and for this country, present not only records of th celebrations under the auspices of state and district societies and various local organizations but also o the commemorations in the U. S. Army commands U. S. Navy districts, and U. S. Public Healt stations.

This volume, as a centenary commemoration, preserves and clarifies the abiding truth in the history of the origination and evolution of general surgica anesthesia. In honoring Horace Wells, dentist and father of it all, the book portrays the basic realities of this great tradition, which is an inspiration fo all dentists and a source of profound thankfulnes for all mankind.

The book will be sold at cost, and the estimate price will be between $4 and $5.

Dr. Eugene M. Clifford,
Chairman, Horace Wells Centenary Committee,
57 Pratt Street
Hartford, Conn.

Please enter my order for ..... copies of the Horac Wells Memorial Volume.

Dr. .....

Street .....

City..... State.....

Dr. Salter Wins Award

Dr. William T. Salter, professor of pharmacology t the Yale University School of Medicine, is the vinner of the Iodine Educational Bureau's first nnual award of $1,000.

The announcement was made at a meeting of the American Pharmaceutical Association in San Fran-isco. Dr. Salter was not present, but will formally ccept the award at the association's spring meeting. The presentation will also serve as the occasion for symposium on iodine.

Dr. Salter, one of the nation's leading authorities n iodine, was cited for his exploration of many undamental questions concerning the function of odine in nutrition and the life processes of the body. His research was on the function of the thyroid land and its relation to blood iodine fractions.

He did significant work with both stable and adioactive iodine, particularly its behavior on the hyroid gland in cases of toxic goiter and cancer.

The Iodine Educational Bureau is a foundation upported by firms, schools and individuals inter-sted in the use of iodine in chemical form.

Dr. Salter has been professor of pharmacology at Yale since the early 1940's. He is the author of the book, "The Endocrine Function of Iodine," and has lso written approximately 100 articles which have ppeared in medical and other publications.

He is currently writing a textbook on pharma-cology.

New Regulation Concerning Foreign Medical Graduates

The Connecticut Medical Examining Board has nnounced the adoption of the following regula-ion concerning graduates of foreign medical chools:

"Effective July 1, 1948 physicians who have graduated from medical schools located outside of he United States, the Dominion of Canada or Great Britain subsequent to January 1, 1940 shall not be eligible to examinations or endorsement leading to icensure to practice medicine in this state."

Under Connecticut law such graduates not eligible or certification for licensure in the state are in-eligible to serve as interns in Connecticut hospitals.

Dr. Lynch to New Departure

Dr. John Mark Lynch, who has been in private practice in Monroe, Wisconsin, has been added to the medical staff of the New Departure Division of General Motors. Dr. Lynch holds a Fellowship* in Occupational Medicine and Hygiene of the Yale University School of Medicine and will serve during the next year in the Medical Department of the Bristol plant under Dr. Preston N. Barton, plant physician.

In addition to his duties in Bristol, Dr. Lynch will attend lectures and conferences in Public Health at the School of Medicine in New Haven and will spend a two-week period with the Bureau of Indus-trial Hygiene of the State Department of Health in Hartford.

Dr. Lynch attended Cathedral Preparatory School in Erie, Pa., his birthplace; the College of Literature, Science and Arts and the Medical School at the University of Michigan in Ann Arbor, Mich.; and the University of Wisconsin at Madison, Wisconsin. At Michigan, where he was a member of Phi Kappa Phi and Alpha Kappa Kappa (medical) fraternities, he received the degrees of bachelor of science and doctor of medicine.

The doctor is a member of several medical societies, and the Knights of Columbus. He is a grandson of Florence Lynch, one of the pioneers of public health activity in Erie, Pennsylvania.

Dr. Davidoff Goes to Poland and Finland

A team of eight United States doctors, headed by Dr. Leo Davidoff, of Marshall Ridge Road, New Canaan, has arrived in Finland after a six weeks' tour of Poland, during which they displayed and explained newest techniques and equipment to the Polish medical leaders.

Dr. Davidoff is chairman of the group, whose tour was sponsored by the Unitarian Service Committee in cooperation with the World Health Organization. He holds the chair of neurological surgery at Columbia University and is associated with Montefiore Hospital in New York.

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*This fellowship is supported by the New Departure Division, General Motors Corporation

CONNECTICUT CANCER SOCIETY

The Connecticut Cancer Program

The program for the control of cancer in Connecticut began as a venture of the medical profession toward the alleviation of this problem. In 1933, a permanent Tumor Study Committee was appointed in the State Medical Society. Two years later, a Division of Cancer Research was created in the State Department of Health. In cooperation with the Tumor Study Committee, the Division of Cancer Research worked out the practical details involved in establishing a record registry in each general hospital in the state and devised methods by which the material abstracted from the hospital charts to the tumor record form could be processed and used. State funds were appropriated as needed to satisfy the requirements of the program as it expanded.

An abstract has been made of every record of every patient with cancer known to any of the general hospitals in the state from January 1935. Included in this series are records for in-patients, out-patients, and individuals not hospitalized in Connecticut but verified as having cancer by any pathology laboratory in one of the general hospitals in the state. This systematic accumulation of hospital records, death records, records obtained through reciprocal arrangements with physicians, health departments and hospitals in 41 states, and reports on known cases obtained through persistent follow-up has netted what appears to be a nearly complete roster of cancer.

The completeness of the data on the record is the result of the interest of the individual physicians. The uniformity of its tabulation is the result of consistent and encouraging supervision of local record workers from the central office. One of the main incentives to the establishment of the central registry has been the complete establishment at the same time of the local hospital registries. To emphasize the fact that the service to the patient at the individual hospital level is the important part of this plan, the original abstracts of the hospital charts are left at the hospital and the carbons are sent to the central office.

Present directors of the Connecticut Cancer Record Registry program are Dr. Matthew H. Griswold, chief of the Division of Cancer and Other Chronic Diseases of the Connecticut State Department of Health, and Miss Eleanor J. MacDonald, Research Statistician.

Since the establishment of a record registry in a local hospital requires the combined efforts of many of the hospital personnel and the Division of Cancer and Other Chronic Diseases, meetings are scheduled at which the whole plan may be explained to as many of the hospital staff as possible.

Clinic workers in the local hospitals then receive what is known as the Tumor Clinic Secretary's Handbook which gives ways in which follow-up of cases may be established. First the physician who treated the cases is sent a list of his patients with the diagnosis and the last date on which each patient was known to the hospital. He is asked to ascertain the status of the patient's health. If the physician has lost track of the patient, permission is sought to trace the patient through the record office. There have been no objections to this practice. Letters are then written from the models given in the Tumor Clinic Secretary's Handbook. These letters are the ones that were found to bring results after hundreds of letters were tried out in two hospitals, the New Haven Hospital in New Haven and the St. Francis Hospital in Hartford.

If these letters do not elicit replies, social service traces the patients of the larger institutions. In the smaller hospitals the Tumor Clinic secretary frequently goes out herself or contacts the visiting nurses association to check the patient. Since 1941 over 1,500 individuals were brought back under observation who had been hospitalized from 1935 through 1939 and who had never been contacted from the time they left the hospital after their initial treatment.

The hospital thus organized often found itself in need of a follow-up clinic, if one had not existed before.

Several of the active clinics in Connecticut have begun in this way, and developed into rounded diagnostic, treatment and follow-up services. The hospital staff, once a registry is begun, continues abstracting the charts of every patient admitted for

the conditions sought and sending the carbons to the state office.

That the Connecticut method has proven advantageous to the state cancer program there can be no doubt. The continual wholehearted cooperation of the medical profession of the state has been a vital factor in the success of the plan; secondly, the wholehearted enthusiasm of the State Registry staff, led by Dr. Griswold and Miss MacDonald, and their efforts in securing the cooperation of hospital staffs throughout the state, have made a voluntary system, which might well have failed, work admirably. Connecticut is a small state, with a large number of hospitals, and a system which draws its records for the most part from hospitals would therefore come closer to including the total registration on cancer, although it might not be as successful in another state of larger size with a more rural population.

Particular commendation should be paid the Connecticut Cancer Registry for its excellent follow-up system. The registry makes a concerted effort throughout the state to find the cases of cancer treated since 1935 in Connecticut hospitals, to determine their present state of health and to guide or assist them in continuing well, in checking recurrences or in receiving palliation. Ingenuity in effecting this massive follow-up has brought to light thousands of living individuals, previously treated for cancer, knowledge of whose existence promises new hope in the cancer field on the subject of cured cases.

Cancer Registry in National Spotlight

Perfected in recent years through the leadership of Dr. Matthew H. Griswold, chief of the Division of Cancer Research for the State Health Department, and his able assistant, Eleanor J. Macdonald, research statistician, the State's Cancer Registry has in the past month gained the acclaim of several national publication sources.

Its study of the State's last 12 years of cancer experience was printed by the American College of Surgeons. This published report drew wide press service comment. A NANA release from Washington termed the study, "the most comprehensive picture of the cancer situation in the United States." A total of 37,863 malignant tumors were diagnosed in the period covered by the Connecticut study.

The Registry holds the star role in the current July issue of *Cancer News*, with one of its workers featured on the front cover, and additional pictures included in the story discussing its operations. Declares the *Cancer News* summary: "The completeness of the data is the result of the interest of individual physicians. . . . The uniformity of its tabulation is the result of consistent and encouraging supervision of local record workers from the central office. . . . One of the main incentives has been the complete establishment of the local hospital registries."

Cancer Society Drive Breaks Record

More than a million contributors raised the Connecticut Cancer Society's 1948 campaign to the record breaking total of more than $338,000. The campaign exceeded last year's total by approximately $1,400. The largest amount raised in any single community came from Hartford, with a total of $75,754, and Norfolk scored the highest per capita contributions, exceeding by more than eight times its quota of $493.

As in past years, 40 per cent of the total campaign fund will be devoted to research and service projects of the American Cancer Society. The remaining 60 per cent is tentatively budgeted to provide the following state cancer services: Cancer Information Service in 16 communities throughout the state—$56,025; aid to local Tumor Clinics in seven communities—$4,200; Detection Centers in four communities—$16,000; statewide Tumor Clinic services —$5,300; state sponsored research—$6,000; administration, campaign, education, and services—$56,570.

New Service Director Appointed

Miss Irma Biehusen, formerly executive director of the Connecticut Branch of the American Academy of Pediatrics, has been appointed state service director of the Connecticut Cancer Society.

Miss Biehusen is president of the Connecticut State Nurses' Association, and prior to her association with the American Academy of Pediatrics was assistant director of nursing service at the Grace-New Haven Community Hospital. She has also served as assistant professor of health education and director of Student Health Service at the Yale School of Nursing, and as consultant in public health for the Hartford Community Council. Miss Biehusen is a graduate of the Yale School of Nursing, and received her master's degree in public health at the Yale University School of Medicine.

THREE KINDS OF TALK

There are three kinds of talk — communication of ideas, communication of happenings, and idle conversation.

People create opinions helpful to physicians when they communicate constructive ideas and news of good events in medicine.

It is a function of public relations to inform people of useful ideas and news concerning medical affairs.

Talk Can Strengthen Or Destroy

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*

Egbert M. Andrews, Hartford
Joseph J. Bruno, New Haven
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Dr. Bruno to VA in Bridgeport

The appointment of Dr. Joseph J. Bruno, New Haven, as chief medical officer of the Veterans Administration Office in Bridgeport was recently announced.

A member of the Society's Committee on Medical Care of Veterans, Dr. Bruno has been acting chief of the Bridgeport VA medical office since last September. The office provides medical care for veterans in Fairfield and New Haven counties.

Dr. Bruno served five years in the Army Medical Corps, including service in the South Pacific and the Guadalcanal campaign, and is regimental surgeon of the 102nd Infantry, Connecticut National Guard, with the rank of major. He is a native of New Haven, a graduate of Yale University, and received his medical degree at the Hahnemann Medical College, Philadelphia.

VA Hospital Internships

A limited number of internships in Veterans Administration hospitals will be offered qualified medical graduates.

The internships will be limited to the 75 VA hospitals now offering residency training programs in cooperation with 59 Class "A" medical schools over the country. They will be further limited to those hospitals which have bachelor quarters available on the station grounds. A survey is in progress to determine what housing is available.

Two types of internships will be available:

(1) "Straight," for surgery, general medicine and other "straight" subjects and

(2) "Rotating," in which interns study, under a rotating schedule, surgery, general medicine and other related subjects. Arrangements will be made for affiliated training in other than VA hospitals for obstetrics and pediatrics. Such affiliated training may not involve more than 20 per cent of a year. The hospital at which such affiliated training is secured must be approved for internship by the Council on Medical Education and Hospitals of the American Medical Association.

"Mixed" internships will not be offered.

Internships will be for one year, subject to reappointment for one year, if desired and recommended by the local dean's committee. The deans' committees, composed of members of university faculties or prominent local doctors, supervise the residency training program and will also supervise internship training.

Annual pay for interns will not exceed $1,800 a year. Quarters, subsistence and laundry will be furnished. The stipend for interns at each hospital will be determined by VA's chief medical director on recommendations of the deans' committees and in conformance with the existing scale of renumeration for interns in the locality.

Interns will be appointed in the VA in accordance with the national policy for all medical schools and hospitals, once each year on November 15, their tour of duty to begin the following July 1 or January 1 following July 1.

The new program is under the supervision of Dr. Paul B. Magnuson, VA's chief medical director and Dr. Edward Harvey Cushing, assistant medical director for research and education in VA's Department of Medicine and Surgery. Dr. Cushing, formerly associate clinical professor at Western Reserve University, Cleveland, Ohio, handled many of the details in establishing VA's residency training program and is in charge of VA's research activities into the causes and cures of little known diseases among veterans.

The Newington VA Hospital affiliated with Yale University is one of the 75 hospitals maintaining a residency training program.

Interim Session — AMA

Registrations and hotel reservations are now being accepted for the second annual Interim Meeting of the American Medical Association at St. Louis, November 30 to noon, December 3, 1948.

On the eve of the Interim Meeting, Saturday, November 27, the first national Medical Public Relations Conference will be held under sponsorship of the AMA at the Statler Hotel.

Planned to be especially valuable to the general practitioner, the Interim Session will offer lecture meetings, conducted by medical leaders on conditions most often seen in daily practice. Subjects to be discussed include diabetes, heart disease, cancer, poliomyelitis, obstetrics, pediatrics, dermatology, genito-urinary conditions, hypertension, anesthesia, tuberculosis, jaundice, laboratory diagnosis, x-ray diagnosis, and physical medicine as applied to the treatment of arthritis.

Diagnosis and treatment will be stressed in a wide variety of clinical conferences, which will be correlated with the lecture meetings. Leading practitioners from all sections of the nation will conduct these conferences.

Evening programs will feature distinguished speakers, the award of the general practitioner medal, and fun. Entertainment will be provided, free of charge to physicians and their guests of course, by stars of the amusement world.

A scientific exhibit with nearly 100 displays will show clinical and pathological material on subjects dealt with in the clinical conferences.

Approximately 115 leading firms will display technical exhibits, which will include new products, equipment, and medical publications. All exhibits will be open from Tuesday at 8:30 A. M. to Friday noon, November 30 to December 3.

Papers will be read at the General Scientific Meetings in the St. Louis Opera House from 9 to 10 A. M. and from 2 to 3 P. M. each day. At least six demonstration units are planned for each half day in the Scientific Exhibit from 10:30 A. M. to 12 noon, and from 3:30 P. M. to 5 P. M. Small rooms will be provided for these demonstrations and provision is being made so that physicians can take all the notes they wish in comfort.

Intermissions in the program will be from 10 to 10:30 A. M., 12 noon to 2 P. M., and 5 P. M. to 6 P. M. each day.

Officers and members of the House of Delegates will stay at the Statler Hotel. Those attending the Medical Public Relations Conference will stay at the Lennox Hotel.

A registration form which enables the physician to save time by securing a registration card in advance is appearing in *The Journal of the American Medical Association* every other week until the Interim Meeting. A convenient blank for making reservations at a number of St. Louis' best hotels, which are within easy walking distance of the St. Louis Auditorium, is also printed in *The Journal.*

All reservations must be cleared through the chairman, Subcommittee on Hotels, American Medical Association, Hotel Reservation Bureau, 1420 Syndicate Trust Building, St. Louis 1, Mo., and must be received before November 9, 1948.

First National Medical Public Relations Conference

A first national Medical Public Relations Conference and Workshop Session, sponsored by the office of the Secretary and General Manager, Dr. George F. Lull, is scheduled for Saturday, November 27, in St. Louis immediately preceding the Secretaries and Editors Conference and the Interim Session.

The Public Relations Conference, it is hoped, will be sufficiently oustanding so that you will want it repeated annually. The date was selected as the most generally convenient and acceptable one for those who will be asked to attend. Invited are the state society public relations directors, the state executive secretaries charged with public relations duties, and the chairman of the public relations committee or other doctor most responsible for public relations policy and activity in your state society.

The Conference will dovetail conveniently with the regular meeting of the Secretaries and Editors which follows it on Sunday and Monday, November 28 and 29.

The proposed program for the public relations meeting deals with concrete problems faced by the state societies under the general theme of "Shooting at Common Targets in Medical Public Relations." A recent survey among state societies showed the need for working toward common public relations objectives.

Six specific problems will be tackled by the discussion leaders—carefully chosen speakers from

fields of opinion research, public relations counsel, and the state medical public relations field itself.

Participants should receive tangible benefit from the frank presentation of the problems and solutions, as well as from taking an active part in the discussions which will follow.

AMA Officials on Government Medicine

A large part of the address of the incoming president of the AMA, Dr. R. L. Sensenich, was devoted to the dangers of government controlled medicine. Dr. E. E. Irons, new president-elect of the AMA is reported to have said that American medicine has won a few of the preliminary skirmishes in the fight against forces that "have been boring from within like termites," endeavoring to deprive medicine of its liberties. Dr. Irons, who has been practicing in Chicago since 1903, wisely warned members of the profession not to be over confident because of the initial victories they have achieved.

"We have knowledge that other attacks are in the offing," he told the House of Delegates of the AMA. "The fight we now must enlarge by arousing the county medical societies to participation is not only a fight to preserve the freedom of medicine. It is a fight to preserve American democracy and the American way of life."

That warning was timely. One of the present dangers is that members of the medical profession will let down, saying: "Dewey has been nominated and will probably be our next President. There's nothing more to worry about."

The ILO is still flourishing. Congress has just enacted legislation appropriating over $1 million annually to the ILO, and has approved the new constitution of the ILO which contains principles foreign to the views of many Americans. We are steadily being committed to alien foreign policies by our State Department and by certain members of Congress.

Dr. Irons' reference to the termites boring from within was most apt. Present at the AMA meetings were Albert Deutsch of *PM;* Mike Davis of the Committee for the Nation's Health and his buddy Dean Clark, M.D., of the PHS; George St. J. Perrott, PHS; and Palmer Dearing, M.D., new deputy Surgeon General of PHS and collaborator with the Physicians Forum, Inc. Termites all!

Secretary of Council on Emergency Medical Service

Dr. Harold R. Hennessy has been appointed to the newly created office of Secretary of the Council on National Emergency Medical Service of the American Medical Association. Dr. James C. Sargent, Milwaukee, Wis., is chairman of the council, which was formed in 1947 to coordinate medical efforts associated with a national emergency.

Dr. Hennessy has been associated with the AMA Council on Industrial Health since February 1946.

Dr. Hennessy, who received his M.D. degree from the University of Minnesota, held various assignments during the war years, his last being that of head of the Public Health Section in the Office of the Surgeon, Fifteenth U. S. Army. He received several military decorations, including the Order of Orange-Nassau Degree of Officer With Swords from the Netherlands government.

White Shop Medical Book Store Expands

As an extension of its present services to the medical, dental, and nursing professions, The White Shop of New Haven acquired the inventory of the Yale University Medical Book Store effective July 1 and has renovated the New Haven Branch at 275 Congress Avenue to accommodate the Medical Book Store's operation in a pleasing setting for members of the profession and students. The White Shop Medical Book Store will be expanded progressively to fill practitioners' needs for an unexcelled selection of medical books.

Already well known to the medical, dental and nursing profession through its sales of professional apparel since 1934, The White Shop with stores in New Haven and Bridgeport is owned by Bernard S. Meyrowitz, histological technician in the Department of Pathology, Yale University School of Medicine, 1934-45.

The New Haven Branch has been operated in conjunction with Mrs. Lillian Meyrowitz, R.N. and graduate of Connecticut Training School for Nurses.

The White Shop Medical Book Store will be under the management of Walter Gustafson, Yale Medical School '49 and former manager of the Yale University Medical Book Store.

National Heart Institute

Establishment of the National Heart Institute as one of the National Institutes of Health in the Public Health Service has been announced by Oscar R. Ewing, Federal Security Administrator.

Surgeon General Leonard A. Scheele, USPHS, at the same time announced the appointment of Dr. Cassius J. Van Slyke as director of the National Heart Institute, under the general supervision of Assistant Surgeon R. E. Dyer, director of the National Institutes of Health. In addition, Dr. Van Slyke will be directly responsible to the Surgeon General for coordination of all heart disease activities in the Public Health Service. He will represent the Service in maintaining relationships with professional societies, voluntary agencies and other civic groups who are interested in the progress of the heart disease program.

Dr. Van Slyke will be succeeded in his post as chief of the Research Grants and Fellowships Division, National Institutes of Health, by Dr. David E. Price, chief of the Research Grants Branch, National Cancer Institute.

The National Heart Institute was created by Congress in the National Heart Act, approved by President Truman, June 16, 1948. The law authorizes the Public Health Service to develop a broad attack upon cardiovascular diseases, now the leading cause of death in the United States. The program will include the conduct of research, financial aid to outside institutions for research and training of professional personnel, fellowships for individual scientists, and grants-in-aid and technical assistance to the States for heart disease control services.

The National Heart Act also directs the appointment of a National Advisory Heart Council to be composed of outstanding scientists and clinicians in the cardiovascular diseases, and representatives of the public. The Council will advise the Surgeon General on all phases of the program developed both in the National Heart Institute and other units of the Public Health Service.

The new Institute will have its headquarters at the National Institutes of Health, Bethesda, Md.

Dr. Van Slyke is 47 years of age. Born in Benson, Minn., he took his medical degree at the University of Minnesota in 1928, and entered the Reserve Corps of the Public Health Service in the same year. In 1932, he was commissioned in the regular Corps of the Service. From 1936 to 1944, Dr. Van Slyke pursued a distinguished career of experimental research at the Venereal Disease Research Laboratory of the Public Health Service, Stapleton, Staten Island, N. Y. In 1945, he was placed in charge of the research grants-in-aid and fellowships program of the National Institute of Health.

Dr. Price, who succeeds Dr. Van Slyke as chief of the Research Grants and Fellowships Division, is 34 years of age. Born in San Diego, California, he took his M.A. in experimental biology at the University of California, and his M.D. at the School of Medicine, University of California, in 1940. He entered the Public Health Service in 1941. After war-time assignments in public health administration and venereal disease control, Dr. Price spent two years at the Johns Hopkins University School of Public Health, where he received the degree of Doctor of Public Health in 1946. Assigned first to the Division of Research Grants and Fellowships, Dr. Price was appointed chief of the Research Grants Branch, National Cancer Institute in 1947, where he has been responsible for the current program of assistance to medical and dental schools for the training of personnel in cancer research and control.

Change Method of Selecting General Practitioner

With more and more attention being directed to the second annual AMA Interim meeting to be held in St. Louis, November 30 to December 3, 1948, attention is called to the resolution, adopted by the House of Delegates at the Chicago session in June, changing the method of selecting the outstanding general practitioner of the year. The selection is made at the Interim Session.

The resolution, which was introduced by Dr. E. S. Hamilton in behalf of the Illinois State Medical Society, set out that the first award was made at the AMA meeting in Cleveland last January, but was "marred by confusion and misunderstanding." The resolution said it was desirable to set up some definite procedure for the selection of the AMA general practitioner of the year, recommending that the selection originate at the county society level and proceed through state organizations so that local or state groups and individuals may pay tribute to the family physician of their choice.

The resolution set in operation the following plan:

1. Each county medical society shall be urged to

name the candidate of its choice as the outstanding general practitioner for the year within its jurisdiction, basing its selection on nominations and recommendations from any responsible source, lay or professional.

2. The name of each candidate so chosen by a county medical society, with all pertinent data, including recommendations of lay groups and individuals, shall be submitted by the county medical society to the state medical society of which it is a component part.

3. Each state medical society, through whatever agency each may designate, shall select from among the candidates submitted by its component county medical societies one name to be declared the outstanding general practitioner within the state.

4. The candidate so selected at the state level shall be the sole candidate from that state, and his or her name, with all pertinent supporting data, shall be submitted to the Board of Trustees of the American Medical Association.

5. The Board of Trustees shall select from the names submitted by state societies the names of three persons, these names to be submitted in turn to this House of Delegates, which shall select one name to be declared the outstanding general practitioner of the United States for the year.

6. Any state medical society desiring to do so may establish and confer a suitable award with fitting public ceremony on the physician it has named as the outstanding general practitioner of that state for the year.

Yellow Jaundice Discussed at 4th International Congresses

Yellow jaundice, or hepatitis, the disease that plagued civilian populations for years and took serious toll among the armed services of many nations during World War II, has recently been found to be caused by at least two specific viruses. These viruses were differentiated as to specific types, transmission, symptoms and prevention at the 4th International Congresses on Tropical Medicine and Malaria held in Washington in May.

Viral hepatitis is the term applied to at least two virus diseases which affect primarily the liver. In this country one form has been referred to usually as infectious or epidemic hepatitis and the other as homologous serum hepatitis or jaundice. Interest in these diseases was intensified by the occurrence of large numbers of cases of jaundice among our troops given yellow fever vaccine.

The known characteristics of the causative agents of these forms of liver disease are considered as viruses. It is suspected that at least two different types of viruses cause these forms of liver disease or hepatitis. Evidence for the existence of these two types of hepatitis virus has been obtained only by means of experiments in human volunteers.

Dr. John R. Neefee of the University of Pennsylvania Medical School refers to these forms of virus as Virus IH (virus of infectious hepatitis) and as Virus SH (virus of homologous serum hepatitis). The results following the introduction of viruses IH and SH into different routes may explain why there are two different kinds of hepatitis (liver inflammation).

Virus IH in the experiments caused acute hepatitis in from 15-37 days. Virus SH required 60-135 days to produce a similar disease. Virus IH caused the disease to appear suddenly with fever and other sharp clinical signs before there was laboratory evidence of the disease. Virus SH caused the disease to appear more slowly, without fever, and frequently the laboratory signs preceded the symptoms of the disease.

Both viruses caused hepatitis when given by injection into the body but only Virus IH caused disease when given by mouth. On the other hand, immune serum protected the volunteers against infection with virus IH but not against virus SH. Volunteers who had either virus infection were not immune to the other form.

Both viruses were found in the blood and feces but not in nasal washings or urine.

These studies confirmed the published works of other investigators that these types of hepatitis are not identical and that they are caused by at least two different virus.

Federal Grants for Mental Health

Award of Federal grants for training of mental health personnel and for research in the field of mental health under the National Mental Health Act for the fiscal year 1949 have been announced by Mr. Oscar R. Ewing, Federal Security Administrator.

The mental health program, authorized by Congress in 1946, received an appropriation of $9,028,000 for the fiscal year 1949. This is to finance a threefold

program of research on mental illness, development of local mental health facilities, and training of mental health personnel, in addition to mental health activities within the Public Health Service. Two million dollars was appropriated for training and research grants and fellowships; approximately $1,430,000 will be spent for training grants, including training stipends for graduate students in the field of mental health; $470,000 for research grants; and $100,000 for research fellowships. In addition, Congress has authorized $2,300,000 to support grants for research and training in years subsequent to 1949. For grants-in-aid to States, Congress appropriated $3,550,000. These funds will be allocated to the States on the basis of their population, financial need, and the extent of the mental health problem. The remaining funds will be spent for the operation of the two Public Health Service Hospitals at Lexington, Kentucky, and Fort Worth, Texas, training and research other than grants and fellowships, demonstrations, consultative services, and administration of the Mental Hygiene Division, Public Health Service.

Grants announced go to universities, hospitals, and clinics to support their training programs, and to provide training stipends, in the fields of psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing, and to support research in the field of mental health. The grants were recommended by the National Advisory Mental Health Council, a body of experts in the mental health field, and were approved by the Surgeon General of the Public Health Service.

The Council considered applications for 205 training grants and 1,099 training stipends, of which it recommended approval of 143 training grants and 561 stipends. With the funds appropriated by Congress for 1949, it was possible to award 86 training grants and 264 training stipends.

Yale University received training grants and grants for stipends in clinical psychology and psychiatric nursing.

Arthritis and Rheumatism Foundation

A new organization, The Arthritis and Rheumatism Foundation, has been organized to promote a united nationwide attack on arthritis and other rheumatic diseases, W. Paul Holbrook, M.D., Tucson, Arizona, president of the Foundation, has announced.

The new Foundation is sponsored by the American Rheumatism Association in cooperation with the National Arthritis Research Foundation, The Detroit Fund for Crippling Diseases, and others interested in bringing about a unity of effort in combatting one of the biggest problems confronting the medical profession—the seven and one-half million persons in the United States afflicted with arthritis or related disorders. Representatives of the three organizations are included in the seventeen prominent physicians and business men on the board of directors of the new Foundation, which has been incorporated in the state of New York.

The medical policies and activities of the new Foundation will be under the direction of a Medical and Scientific Committee now being organized.

The chairman of the board of directors is Floyd B. Odlum, Indio, California, president of the Atlas Corporation.

New Iron Lung Developed

A model of a rubberized cloth or plastic sheet "iron lung" respirator which can be mass produced at low cost—and would be so compact and light in weight that it could be transported in a suitcase instead of truck or ambulance—has been developed at Yale University.

The model—which can be collapsed and folded up—has already been tested successfully at Yale on an experimental animal.

A man size respirator of this type has been designed and it is expected to be developed on a commercial basis.

The new type respirator is primarily for use in handling cases of infantile paralysis. If commercial development is successful, the cloth respirator will multiply many times over the availability of treatment of this type for poliomyelitis cases, since it can be produced for a fraction of the cost of the present heavy and rigid respirator.

Industrial Accidents Less in 1947

A total of 19,740 industrial accidents was reported in Connecticut during 1947, cumulated from the monthly figures of the Bureau of Labor Statistics of the Connecticut Department of Labor. Compared with 1946, this total represents a 1.2 per cent reduction in number from the 19,977 accidents reported for that year. The number of fatal cases for all reporting industries in 1947 was 104 per cent lower than in 1946, declining from 47 to 23. Included in the present total were 483 amputations, an increase of 22 from the previous year.

MILITARY BIOGRAPHIES (*Concluded*)

These brief sketches of military experience of members of the Society have been compiled from data taken from questionnaires completed by each medical officer. Biographical material for some officers is lacking because questionnaires were not returned.

)ODWARD, JOSEPH C., New Lon- ; b. 1909; Columbia 1935; Navy— ober 11, 1943 Lt., Lt. Comdr. Novem- 1, 1945; Service Terminated May 31, 6; Duty—Portsmouth, Va.; Invasions Normandy, Southern France; Base spital #5 Casablanca, French Mor- o (European Theatre of Operations); np White Naval Hospital, Medford, gon; Awards—3 battle stars.

)ODWORTH, JOHN A., Moosup ntered service from Syracuse, N. Y.); 1915; Syracuse 1939; Army Air—July 1941 Lt., Captain March 1, 1942, jor October 12, 1942; Service Termi- ed December 6, 1945; Duty—Mitchell ., N. Y.; Groton, Conn.; Baltimore, .; Philadelphia, Pa.; School of Avia- n Medicine, Randolph Fld., Tex.; ght Surgeon—North African-Medi- ranean-China-Burma-India Theatres of eration; Awards—Presidential Unit ation; 6 battle stars; Bronze Arrow- ad.

)OL, JOSEPH M., New London; b. 14; New York Medical College 1941; my—July 1, 1942 Lt., Captain 1944; vice Terminated April 16, 1946; Duty Carlisle Barracks, Pa.; Ft. Storey, Va.; mp Reynolds, Pa.; Camp Ellis, Ill.; Ord, Calif.; 91st Field Hospital— ilippines and Japan (Asiatic-Pacific eatre of Operations); Awards— onze star; 1 battle star.

RAY, EDWARD H., JR., Litchfield; 1903; Yale 1932; Navy—May 5, 1941 , Lt. Comdr. November 1, 1942, Com- nder July 10, 1945; Service Termi- ted February 12, 1946; Duty—Brook- n, N. Y.; New York, N. Y.; USS ntiac (Atlantic); USS Windsor (Asi- c-Pacific Theatre of Operations); onx, N. Y.; Awards—6 battle stars.

RIGHT, HAROLD S., Greenwich ntered service from Brookline, Pa.); 1914; Cornell 1939; Army—October 1942 Lt., Captain November 1943; rvice Terminated February 17, 1946 Major); Duty—Camp Claiborne, La.; orth African-Mediterranean Theatre of perations; Awards—4 battle stars.

WRONA, EUGENE A., Stamford (Entered service from Glen Lyon, Pa.); b. 1917; Hahnemann 1943; Army—March 10, 1944 Lt., Captain February 1, 1945; Service Terminated September 9, 1946; Duty—Carlisle Barracks, Pa.; Oliver General Hospital; 131st General Hospital (European Theatre of Operations); Camp Siebert, Ala.; Ft. Meade, Md.

YASSER, ISIDORE, Bridgeport (Entered service from Brooklyn, N. Y.); b. 1911; University of Colorado 1940; Army—July 8, 1942 1st Lt., Captain January 8, 1944; Service Terminated March 7, 1946; Duty—In Continental United States.

YAVIS, JOHN C., New Haven; b. 1894; Athens (Greece) 1918; Army—September 12, 1942 Major, Lt. Colonel November 1945; Service Terminated March 5, 1946; Duty—Lovell General Hospital, Ft. Devens, Mass.; 109th Station Hospital —332nd Station Hospital—71st Station Hospital (Asiatic-Pacific Theatre of Operations).

YESNER, RAYMOND, Newington (Entered service from Massachusetts); b. 1914; Tufts 1921; Army—January 15, 1944, 1st Lt., Captain March 17, 1945; Service Terminated January 23, 1947; Duty—Carlisle Barracks; Army and Navy General Hospital, Arkansas; Station Hospital, Camp Patrick Henry, Virginia; Station Hospital, Fort Eustis, Virginia; Woodrow Wilson General Hospital, Virginia; Regional Hospital, Camp Lee, Virginia; Award—Meritorious Service Unit Plaque.

YOBURN, MICHAEL M., Danbury; b. 1913; Boston University 1939; Army—January 14, 1941 Lt., Captain August 4, 1943; Service Terminated February 6, 1946; Duty—Camp Blanding, Fla.; Camp Shelby, Miss.; Camp Claiborne, La.; European Theatre of Operations); Awards—5 battle stars.

YOHN, ALBERT K., South Norwalk; b. 1910; Columbia 1935; Army—September 22, 1942, Captain July 1943; Service Terminated February 3, 1946; Duty—Camp Rucker, Ala.; Camp Horn, Ariz.; Camp San Luis Obispo, Calif.; Territory of Hawaii; Palau; New Caledonia; Leyte, P. I.; Aomori, Japan (Asiatic-Pacific Theatre of Operations); (Removed to Washington, D. C.).

ZAFF, FRED, New Haven; b. 1912; Michigan 1937; Army—September 24, 1943 Lt., Captain February 1, 1945, Major January 21, 1946; Service Terminated November 13, 1946; Duty—162nd General Hospital-England; 194th General Hospital-France and Belgium; 166th General Hospital-France.

ZAGLIO, EDMOND R., Manchester; b. 1909; Columbia 1933; Army—September 29, 1942 Lt., Captain July 23, 1943; Service Terminated March 6, 1946; Duty —179th Station Hospital (Aleutians); Ashford General Hospital, West Va.; Award—Army Commendation Ribbon.

ZAGRANISKI, RAYMOND J., New Haven; b. 1915; Yale 1942; Army—July 3, 1943 Lt., Captain October 1944; Service Terminated August 6, 1946; Duty—Lovell General Hospital, Ft. Devens, Mass.; Ft. Adams; Ft. Ethan Allen, Vt.; Camp Edwards, Mass.; Camp Gordon Johnston, Fla.; Camp Ellis, Ill.; Ft. Bragg, N. C.; England-France-Germany (European Theatre of Operations).

ZARIPHES, CONSTANTINE, Rocky Hill; b. 1898; Boston University 1924; Army—July 14, 1943 Captain, Major November 5, 1945; Service Terminated December 13, 1945; Duty—Lovell General Hospital, Ft. Devens, Mass.; Northington General Hospital, Tuscoloosa, Ala.; Ft. McClellan, Ala.; Camp Sutton; 102nd Reinforcemnt Bn. — England-France-Belgium-Germany (European Theatre of Operations).

ZARKIN, OSCAR H., Hartford (Entered service from Roxbury, Mass.); b. 1912; Tufts 1937; Army—August 12, 1942 Lt., Captain January 1944; Service Terminated March 1946; Camp Langdon, Portsmouth, N. H.; Carlisle Barracks, Pa.; Camp Kilmer, N. J.; Tilton General Hospital, Ft. Dix, N. J.; Ft. McClellan, Ala.

ZAUR, I. SIDNEY, Bridgeport; b. 1907; Yale 1932; Army—October 7, 1942 Lt., Captain January 1944, Major December 1945; Service Terminated April 1, 1946; Duty—Lovell General Hospital, Ft. Devens, Mass.; 27th Field Hospital—52nd Field Hospital — Solomons and Philippines (Asiatic-Pacific Theatre of Operations); Award—Unit Citation.

ZAVADIER, NATHAN, Bridgeport.

ZEMAN, MICHAEL S., Hartford (Entered service from New York City); b. 1910; Louisville 1936; Army—November 7, 1940 Lt., Captain June 13, 1942; Service Terminated November 7, 1945; Duty—Ft. Hancock, N. J.; Camp Phillips, Kans.; 250th Station Hospital — 91st Evacuation Hospital — 158th General Hospital — 103rd General Hospital (European Theatre of Operations); Camp Edwards, Mass.; Awards—2 battle stars.

ZIELINSKI, JOHN B., Bridgeport (Entered service from Fall River, Mass.); b. 1908; Jefferson 1934; Army—November 30, 1942 Captain, Major September 18, 1943, Lt. Colonel November 13, 1944; Service Terminated January 25, 1946; Duty—Walter Reed General Hospital, Washington, D. C.; 187th Gene Hospital, Hanrahan Staging Area, La. Longview, Tex.; 60th General Hospit El Paso, Texas—New Guinea and Phil pine Islands (Asiatic-Pacific Theatre Operations); Awards—3 battle stars.

ZIMMERMAN, HARRY M., N Haven; b. 1901; Yale 1927; Navy February 21, 1944 Lt. Comdr., Co mander November 8, 1945; Service T minated May 21, 1946; Duty—St. Alba N. Y.; USN Medical Research Unit # Guam, M. I. (Asiatic-Pacific Theatre Operations); (Removed to New Yo N. Y.).

CORRESPONDENCE

Veterans Administration

Branch Office No. 1
55 Tremont Street
Boston 8, Massachusetts

August 18, 1948

To: Manager VA Regional Office
95 Pearl Street
Hartford 4, Connecticut

SUBJ: Streptomycin Prescribed by Fee Basis Physicians

1. This is in reply to your letter of August 16, 1948.

2. In early 1946, Dr. Paul R. Hawley, chief medical director, set up a Streptomycin Committee in Central Office and required that all veterans receiving streptomycin for any reason be previously approved for such treatment by the Committee in Central Office.

3. Since that date, branch office streptomycin committees have been authorized to supervise the use of streptomycin in veterans with tuberculosis in any of its forms.

4. No veteran with tuberculosis is to receive streptomycin unless he has been previously approved for such treatment by the Branch or by the Central Office Streptomycin Committee. In general, such veterans will be referred to the Branch Office Committee for approval.

5. The use of streptomycin in the treatment of diseases other than tuberculosis no longer requires Branch or Central Office approval. A veteran with a non tuberculous disease may be given streptomycin by his private physician and the drug may be paid for in such instance by the Veterans Administration under the so-called "Home Town Medical Care Program."

6. Let it be clearly understood that no veteran will be refused streptomycin treatment where indicated; but he may very well be required to transfer to a Veterans Administration hospital for such treatment.

7. No private physician will be approved to give streptomycin to a veteran for tuberculosis in any form under any circumstances by the Veterans Administration at the present time.

8. It is the policy of the Veterans Streptomycin Committee, Branch No. 1, at the present time, to require all veterans with tuberculosis who receive streptomycin therapy to go to a specific hospital for such treatment.

/s/ Francis B. Carroll, M.D.,
Branch Medical Director

Published at request of Chief Medical Officer, Veterans Administration, State of Connecticut.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Charles W. Goff, West Hartford
President-elect, Mrs. Ralph L. Gilman, Storrs
First Vice-President, Mrs. F. Erwin Tracy, Middletown
Second Vice-President, Mrs. Charles H. Sprague, Bridgeport
Recording Secretary, Mrs. Paul Vestal, Woodbridge
Treasurer, Mrs. Frank DiStasio, New Haven
Corresponding Secretary, Mrs. J. Whitfield Larrabee, West Hartford

Mrs. Arthur H. Jackson of Washington has been appointed State Chairman of the Nurses Recruitment Project. Each of the counties will also have a chairman and the best method of helping in this important work will be studied and carried out as soon as possible.

We regret that the name of Mrs. H. Bertram Lambert was omitted from the roster of Fairfield county in the August Journal. Mrs. Lambert was the first president of the State Auxiliary and though a member of Fairfield County is now living in Rocky Hill.

Mrs. Ralph L. Gilman, Storrs, our president-elect, was one of our delegates at the twenty-fifth annual meeting of the Woman's Auxiliary to the American Medical Association in Chicago on June 21-24, 1948 and her report of the meeting follows:

It was a most interesting experience to attend the twenty-fifth annual convention. The meetings were well planned and a great deal of material was covered in the days allotted. There was even a little time allowed for sight-seeing before and after the sessions during the week.

It was a pleasure to meet the national officers and committee chairmen and to exchange ideas and glean new ways of accomplishing our common objectives. More and more it became evident that our duty and purpose should be to promote friendliness, medical education, and better medical care for every American.

I was charmed by the gracious manner in which Mrs. Eustace Allen, president, carried out the procedure and routine of the various sessions with the active assistance of her national officers and the convention chairman, Mrs. Rollo K. Packard. The teas and luncheons were delightful and afforded an informal opportunity to meet doctors' wives from all over the country.

The national organization chairman reported a great increase in membership, both in new county organizations and in additional members in already established auxiliaries. She referred to the fine work done by Mrs. James R. Miller of Hartford, chairman for the eastern district, in developing new auxiliaries during the year. There are now over 42,000 paying members with many more added since the annual reports were filed.

The budget, a very modest one for such a large organization, was approved increasing the total from $9,290 this past year to $12,129 for 1948-49. Copies will be sent to the state officers.

The new plan, to send a copy of the National Bulletin to all auxiliary members, should be a great help in reaching all members with the news, projects, and problems common to all. Many states have established their own publication as well as maintaining a regular space in their *State Medical Journal*. The August issue of the *National Auxiliary Bulletin* contained the highlights of the addresses and reports given so I will give only a quick summary of my impressions.

Dr. Fishbein and Dr. Bortz gave interesting and informative luncheon talks elaborating on the opportunities for the growing auxiliary to become informed and to become a force for the good in the advancement of the medical profession and in the development of better public relations between the profession and the general public.

The reports of the national chairmen and the abbreviated reports of the state presidents were most enlightening and stimulating to future efforts. The program chairman referred to the many projects and plans accomplished, such as the study of prepayment plans, cancer and heart disease education, health days with other organizations cooperating, nurse recruitment and nurse and student scholarship projects, and surveys and programs devoted to better school and general health for the community.

The public relations chairman emphasized many of the projects just mentioned as well as use of the

A.M.A. platters for radio and organization use. She stressed the frequent cooperation with other community organizations to develop real interest and support. Health councils were stressed as a means of pooling community health problems and information.

Nurse recruitment and nursing scholarships were stressed as continuing needs. Many state and county auxiliaries have done a great deal in starting nursing and high school officials to develop essay and poster contests, special assembly programs, hospital visitation by interested students, etc., should prove effectual. Contest prize money was furnished by the medical society in some places, showing their stake in the program.

The sale and use of *Hygeia* has advanced during the past year and is a source of authentic health education for doctors' families as well as in our schools, colleges and for the general public.

A most impressive memorial service was held for auxiliary members who had died during the past year.

The registration for the convention totalled about 840, of whom 103 were guests. From Connecticut several members and guests were registered and at least 4 delegates were in regular attendance at the sessions. The report for Connecticut was prepared by Mrs. Robert Cook, past president, and read by Mrs. Gilman in the absence of the president and past president.

Dr. Roscoe Miller, president of the Chicago Medical Society, in extending greetings stressed the prime aim of the A.M.A.: namely, "the best care for the American patient," and the need for the auxiliary to help inform the public of this in an indirect way. A final motto quoted at one of the sessions:

"Be friendly, be informed, be vigilant"

The national officers and chairmen of the standing committees for 1948-1949 are as follows:

President: Mrs. Luther H. Kice, 95 Brook St., Garden City, Long Island, N. Y.

President-elect: Mrs. David Allman, 104 St. Charles St., Atlantic City, N. J.

Vice-Presidents: 1st: Mrs. Ralph Eusden, 4360 Myrtle Ave., Long Beach 7, Calif.; 2nd: Mrs. William W. Potter, 129 Kenesaw Terr., Knoxville, Tenn.; 3rd: Mrs. Lloyd C. Harvey, 417 Ardussi Ave., Saginaw, Mich.; 4th: Mrs. Robert Flanders, North River Rd., Manchester, N. H.

Treasurer: Mrs. Arthur A. Herold, 1166 Louisiana Ave., Shreveport, La.

Constitutional Secretary: Mrs. George Turner, 3009 Silver St., El Paso, Texas.

Standing Committee Chairmen: Finance: Mrs. Scott C. Applewhite, 240 Bushnell St., San Antonio, Texas; *Hygeia:* Mrs. Aldace W. Hammond, 214-4th St., Beaver Dam, Wisconsin; Legislation: Mrs. Charles L. Shafer, 219 North Sprague Ave., Kingston, Pa.; Organization: Mrs. Ralph Eusden, 4360 Myrtle Ave., Long Beach 7, Calif.; Publications: Mrs. James P. Simonds, 234 E. Pearson St., Chicago 11, Ill.; Program: Mrs. Harry F. Pohlmann, 28 Railroad Ave., Middleton, N. Y.; Public Relations: Mrs. Asher Yaguda, 61 Lincoln Park, Newark 2, N. J.; Revisions: Mrs. Roscoe Mosiman, 2686 Magnolia Ave., Seattle, Wash.

Special Committees: Reference: Mrs. Rollo K. Packard, 14093 Davana Terr., Sherman Oaks, Calif.; Historian: Mrs. Jesse P. Hamer, 1819 N. 11th Ave., Phoenix, Ariz.; Parliamentarian: Mrs. Alfred L. Madden, 44 S. Allen St., Albany, N. Y.

The fifth annual conference of state presidents and presidents-elect and national chairmen of standing committtees will be held Thursday and Friday, November 4 and 5, 1948 at the Hotel Sherman in Chicago. The pre-conference meeting of the Board of Directors will be held on November 3.

Fairfield County

The power motor sewing machine and attachments that were voted for at the last board meeting have been presented to Laurel Heights rehabilitation work. Mrs. Ruth Kenzie, director of rehabilitation, wrote Mrs. J. Grady Booe, president, that the machine had been in constant use and expressed the appreciation of the patients for this useful gift.

Litchfield County

At the last meeting of the Woman's Auxiliary two projects were adopted for this year, Nurse Recruitment and Health Days or Projects. The organization also voted the sum of $25 to the American Women's Hospital Association for the support of the fine work they are doing both here and overseas.

Mrs. Royal A. Meyers, Watertown, was a delegate at the American Medical Association Convention in Chicago. She reported that it was voted by the majority of members present to increase the national dues to $1 instead of the previous 25 cents. Connecticut members present voted against the change.

SPECIAL NOTICES

CONNECTICUT VA MEDICAL SOCIETY

The weekly medical conferences of the Connecticut Veterans Administration Medical Society are held every Thursday at 8:30 A. M. at the Veterans Administration Building, 95 Pearl Street, Hartford. The medical profession is invited to attend these meetings.

The October program follows:

October 7

Gastric Surgery

Sidney S. Quarrier, M.D., associate surgeon, Hartford Hospital

October 14

Treatment of War Neuroses

Isidor Schnapp, M.D., chief mental hygiene clinic Veterans Administration Regional Office, Hartford

October 21

Medical Aspects of Dermatology

E. Myles Standish, M.D., visiting dermatologist, Hartford Hospital

October 28

Psychosomatic Medicine

Charles T. Bingham, M.D., assistant physician, Hartford Hospital

The following clinical conferences will be held during October at the Veterans Administration Office, 355 Fairfield Avenue, Bridgeport, from 8:30 A. M. to 9:30 A. M. on the dates indicated:

October 6

Vagatomy in Treatment of Peptic Ulcer

Surgical Aspect

William H. Curley, Jr., M.D., F.A.C.S., Bridgeport

Medical Aspect

M. David Deren, M.D., Bridgeport

October 13

Rheumatoid Arthritis

Russell V. Fuldner, M.D., New Haven, assistant professor, orthopedic surgery, Yale University School of Medicine

October 20

Current Trends in Treatment of Diabetes

Barnett Greenhouse, M.D., New Haven, attending physician, Grace-New Haven Community Hospital

October 27

Pulmonary Diseases in General Practice

H. Philip Dinan, M.D., Stratford

STATE NURSES ANNUAL MEETING

The Connecticut State Nurses Association will hold its annual meeting at the Stratfield Hotel, Bridgeport, October 7 and 8.

NEW ENGLAND DIABETES ASSOCIATION

The fall meeting of the New England Diabetes Association will be held on Wednesday, October 20, 1948, at 8:00 P. M. in the Cheever Amphitheater of the Boston City Hospital.

The speaker of the evening will be Dr. George W. Thorn, Physician in Chief, Peter Bent Brigham Hospital and Hersey Professor of the Theory and Practice of Physic, Harvard Medical School, whose subject will be:

"Some Fundamental Endocrine Relationships in Diabetes."

Following the clinical program there will be an important business meeting of the Association to discuss future policies of the Association.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

The 28th annual convention of the National Society for Crippled Children & Adults, Inc., will be held at the La Salle Hotel, Chicago, November 15-17.

Many outstanding speakers in the fields of medicine, health and education will be on hand to present facts on progress in work with the handicapped during the past year, according to Lawrence J. Linck, executive director.

The convention will be attended by physicians, therapists, educators, workers with the handicapped and representatives of National Society's more than 2,000 state and local units throughout the United States, Canada, Alaska and Hawaii.

AMERICAN ACADEMY OF GENERAL PRACTICE

March 7, 8 and 9 are the dates selected by the Board of Directors for the first Annual Scientific Assembly of the American Academy of General Practice, to be held in Cincinnati next year. Plans are being made to accommodate more than two thousand members of the Academy.

The annual Assembly will open on Monday morning, March 7, at 10:00 A. M. with a brief business meeting. Scientific papers and symposium will be presented on Monday, Tuesday and Wednesday. The meeting will close on Wednesday, March 9, at noon. The annual banquet will be held on Tuesday evening.

The officers, directors and members of the official committees urge that all members make their plans now to

attend this first Annual Scientific Assembly of the Academy. It will undoubtedly be the most valuable and the most pleasant meeting for general practitioners in any section of the country next year.

All requests for hotel accommodations should be addressed to Mr. J. S. Turner, Cincinnati Convention Bureau, Dixie Terminal Building, Cincinnati 2.

AMERICAN GOITRE ASSOCIATION

This meeting will be held in the Hotel Loraine, Madison, Wisconsin, May 26, 27 and 28, 1949.

The program for the three day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Madison, Wisconsin, May 26, 27 and 28, 1949, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten double spaced copy sent to the Corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than March 15, 1949. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any journal selected by the author.

UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Biltmore Hotel in Los Angeles, May 16-19, 1949.

For full particulars write the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis 3, Tennessee. Essays must be in his hands before February 15, 1949.

THE DOCTOR'S OFFICE

Richard T. Atkins, M.D., announces the opening of an office for the practice of internal medicine at 218 Bedford Street, Stamford.

Arnold H. Becker, M.D., announces the opening of an office for the practice of medicine at 133 Main Street, Bristol.

Marion Cusnir, M.D., announces the opening of an office for the practice of medicine and surgery at 3 Colony Street, Meriden.

Ralph Gancher, M.D., announces the opening of an office for the practice of internal medicine at 195 Grove Street, Waterbury.

John D. Horgan, M.D., announces the opening of an office for the general practice of medicine and surgery at 55 Williams Street, East Hartford.

Gerald Krosnick, M.D., announces the opening of an office for the practice of obstetrics and gynecology at 38 Trumbull Street, New Haven.

Michael C. Luciano, M.D., announces the opening of an office for the practice of medicine at 2085 North Avenue, Bridgeport.

Vincent A. Manjoney, Jr., M.D., announces the opening of an office at 2464 East Main Street Bridgeport.

Richard V. Newcombe, M.D., announces his association with Kenneth K. Kinney, M.D., for the practice of radiology at 29 North Street, Willimantic.

Jacques Robbins, M.D., announces the opening of an office for the general practice of medicine and surgery in the Strand Theater Building, Thompsonville.

Hilliard Spitz, M.D., announces the opening of an office for the practice of internal medicine and cardiology at 183 Williams Street, New London.

Louis M. Yavetz, M.D., announces the opening of an office for the practice of medicine at 95 North Main Street, Waterbury.

Henry M. Young, M.D., announces the opening of an office for the practice of general surgery at 3 Franklin Square, New Britain.

Norman Zeldis, M.D., announces the opening of an office for the general practice of medicine at 44 Albany Avenue, Hartford.

OBITUARIES

Emmanuel A. Henkle, M.D.
1876 - 1948



Dr. Emmanuel Alexander Henkle died February 6 at his home, 51 Federal Street, New London, where he also had his office for the past 46 years. Dr. Henkle was born in Russia in 1876 and came to the United States at the age of 14. He studied medicine at the University of Cornell School of Medicine and was a member of the first class to graduate from that school in 1899. The following year, having married Sonia Shmauk of Oakdale, he settled in New London.

In those days all the doctors did general practice but Dr. Henkle did an unusually large amount of obstetrics, though later he turned almost exclusively to general surgery. While on the staff of the old Memorial Hospital he was active in both these branches of medicine. When the Memorial Hospital was amalgamated with the Lawrence Hospital Dr. Henkle served as obstetrician. With the development of the Home Memorial Hospital he became its chief of staff and chief surgeon. Dr. Henkle was a member of the American Medical Association, the Connecticut State Medical Society, the New London County Medical Association, and the New London City Medical Society.

In public service Dr. Henkle devoted two years on New London's Board of Education, and served the Lyman Allyn Museum as a director. Although his consuming passion was the practice of his profession, Dr. Henkle sang well, played the violin, composed several pieces of music, wrote poetry and was an enthusiastic collector of antiques.

Besides his wife Dr. Henkle is survived by two sons, Dr. Robert T. Henkle and city manager Edward R. Henkle, both of New London, and a daughter, Dorothy K. Cooper of New York, a sister in New York, a brother in California and five grandchildren.

That many physicians, former patients and associates held Dr. Henkle in high regard was amply demonstrated by the overflowing assemblage which came to pay a last tribute to him.

Charles G. Barnum, M.D.

Victor Alexander Kowalewski, M.D.
1873 - 1948



Victor Alexander Kowalewski died April 3, 1948 at his home, 597 Campbell Avenue, West Haven after an illness of six years. Death was due to hypertensive cardiovascular disease. He was born in

Bridgeport on October 6, 1873. He was the son of Josef and Elizabeth Eberhardt Kowalewski. His father was born in Poland and his mother in Switzerland.

Following graduation at Yale, B.A. 1899, he entered the Yale Medical School, receiving an M.D. degree in 1902. In 1903 he became associated with Dr. Benjamin L. Lambert of New Haven in the general practice of medicine, obstetrics and surgery. In 1910 he was appointed medical examiner for the towns of West Haven and Orange, in which capacity he served faithfully for some thirty-five years. For many years he was on the staffs of New Haven and Grace Hospitals. Also he was attending physician to the Methodist Church Home for the Aged, West Haven, and attending physician at the Florence Crittenden Mission.

Dr. Kowalewski had a wide and enthusiastic interest in local civil affairs. He held membership for years in the New Haven Rotary Club, New Haven Colony Historical Society, the New Haven Country Club, the Graduates Club, and the Quinnipiack Club. He also was a member of the local, county, state, and national Medical Associations. During World War I he was a member of Connecticut Home Guard and on the Connecticut Board of Examining Physicians for Army Draft. During World War II he was an examining physician for Local Board 14-C of Connecticut. He was a member of Annawon Lodge, No. 115, A. F. & A. M., Noble of Pyramid Temple of the Mystic Shrine, and a 32nd degree Mason.

On October 14, 1903 Dr. Kowalewski married Mabel Edna Lane of New Haven. She survives him, together with four children, Victor Alexander, Jr., of New Haven, Margaret of Boston, Frederick Lane, and Mrs. Edward Sanback of West Haven; and two grandchildren, Victor Kowalewski, III, and Frederick Lane Sanback.

Dr. Kowalewski devoted the major part of his life to the practice of general medicine. He was an ideal family doctor of the old school. He was intensely devoted to his patients, charitable with the poor, and skilful in the management of the psychological as well as the physical problems of the ill. He always maintained an active interest in current world affairs as well as medicine. Despite his illness, he carried on a limited medical consultation service from his bedside. His hobbies were automobiles and his cottages at Lake Monomonack, New Hampshire where he and his family spent the summer months for about thirty years.

Dr. Kowalewski was a man of commanding personality—a precise, vigorous, clear thinker—unusually skilful in mechanical matters. His loyalty and friendliness endeared him to his medical associates; his kindliness and devotion won him a lasting loyalty from his many patients.

Marvin M. Scarbrough, M.D.

Frank B. Converse, M.D.
1865 - 1948



Frank Converse died at his home in Willington April 4, 1948. He was 82 years old. He was born in Wales, Massachusetts, the son of a country doctor who later moved to Ashford, Connecticut. Frank was graduated from the Eclectic Medical College of Cincinnati in 1893, and set up his office in nearby Westford. He was so successful that in the 12 years before he moved to Willington he owned outright two horses, a sleigh, and carriage and had amassed $600. He entered with enthusiasm into the social and political life in his new community while never flagging in his interest in what was new in medicine.

For a number of years Dr. Converse was chief of staff of the Johnson Memorial Hospital and president of the Medical Board. He was a member of the AMA and of the Tolland County Medical Association, and past president of the latter. He was medica

examiner for Willington, Ashford, Union and Mansfield, and served several terms in the State Legislature as Representative from the Town of Willington.

So much for statistics, unenlightening and clammy enough when given about things or events, doubly uninforming when applied to a man as vivid as was Frank Converse. Of the many facets of his character I'll take time to talk of just one. He was valiant. He was a hard loser against disease and no matter how bad things were going, that particular patient wasn't going to die—not yet. There was always some other drug to give, some other measure to try. This fighting spirit was so evident to his families, it inspired a confidence in him almost beyond belief. I doubt that any of them ever asked for a consultant, but if he wanted one they were indulgent and let him have his way. The consultant was always rated according to the enthusiasm with which he agreed with Frank Converse. I can't imagine a physician whose whole territory was so loyal to him.

During the last years of his invalidism his former patients had to call on us Stafford physicians, but most of them intimated, quite a few stated baldly, that if Frank was again available Stafford doctors would still be respected, but ignored.

1943 marked the completion of 50 years of practice, all in one neighborhood. To commemorate it he was guest of honor at a meeting of our County Association, and was presented with a scroll which concluded with this paragraph:

"Presented in appreciation of conscientious and skilful response to every patient who called on him for help, of his invariable good fellowship with us, his confreres, of his fine citizenship, and finally in applause for his manifestation of every quality a general practitioner could have."

John P. Hanley, M.D.

OUR NEIGHBORS

Massachusetts

The Worcester District Medical Society now has the use of a building purchased by the Worcester Medical Library, Inc.

New Jersey

The New Jersey state legislature at its last session passed a compulsory sickness compensation program. As set up it will be similar to that in California with some variation in taxing provisions.

NEWS *from County Associations*

Fairfield

R. Anthony Tella of Stamford has been appointed clinical instructor in anesthesiology on the faculty of Marquette University School of Medicine. Dr. Tella is chief of the department of anesthesiology at the VA hospital in Milwaukee. He took his postgraduate training in anesthesiology at Yale.

Fritz Carleton Hyde, for many years chairman of the State Medical Examining Board and a practitioner in Greenwich from 1901 to 1933, died at his summer home in Harwichport, Massachusetts, on September 4. He retired from active practice in 1933 and moved to East Dennis, Massachusetts, and later to New York City.

Hartford

Max Climan, radiologist in Hartford for 29 years, died on August 18 at Mt. Sinai Hospital after a brief illness. Dr. Climan was a member of the staffs of Mt. Sinai, McCook Memorial, and Newington Veterans Administration Hospitals.

Benjamin V. White of Hartford and C. P. LeRoyer, Jr., formerly assistant resident in medicine at the Hartford Hospital, are the authors of "Diagnostic and Therapeutic Problems in Diverticulitis" published in *The New England Journal of Medicine*, August 12, 1948.

Dr. Herman Edelberg has closed his Granby office and will devote full time to maintaining his office in Simsbury.

James R. Miller of Hartford, delegate to World Health Assembly, addressed the 135th annual meeting of the Vermont State Medical Society at Burlington in September on "The World Health Organization—Our Concern in the Health of Other Peoples."

Litchfield

Charles S. Howard of Malden, Massachusetts has been appointed resident physician at Charlotte Hungerford Hospital, Torrington. Dr. Howard is a graduate of Tufts Medical School.

Middlesex

Dr. Harold E. Smith of Middlefield has been appointed health officer for Durham, succeeding Dr. Henry Sherwood.

New Haven

Harold M. Marvin of New Haven will be one of the speakers at the New England Postgraduate Assembly to be held in Boston the first week in November. His subject: "Low Salt Regime and Other Measures in Treatment of Congestive Heart Failure."

Dwight Milton Lewis, director of communicable diseases in the New Haven City Health Department prior to his retirement in 1946, died in New Haven Hospital on August 31.

Frank Mongillo of New Haven has been elected an associate member of the American College of Chest Physicians.

New London

In August the Officers, Board of Trustees, and the Program Committee of the New London County Medical Association had a dinner meeting at the Cinderella Inn, Waterford, with a full attendance. The meeting was presided over by Dr. John Suplicki, chairman of the Board of Trustees. Various matters were discussed and an outline of speakers for the coming season was discussed. Those expected to be with us are Roger C. Graves of Boston, Dr. William Damashek of Boston, Dr. Alexander Brunschwig of New York City, and Dr. Leland McKittrick of Boston. With these speakers definitely assigned the prospect for a most successful season is assured. Our meetings are held at 8:30 P. M. on the first Thursday of each month, starting in October at Uncas-on-the-Thames. A cordial invitation is given to each physician in the State Medical Society who might be in the vicinity of Norwich.

Dr. Charles G. Barnum of Groton was appointed chief-of-staff of the Lawrence-Memorial Hospital, New London, effective August 1, 1948. Our sincere congratulations for a well and richly deserved honor. Charley Barnum commands the utmost respect of every member of New London County. Best wishes.

The Lawrence-Memorial Hospital, New London, has opened its new X-ray Department under the direction of Dr. Frederick Fagan. The department has been completely remodeled, and in addition to the diagnostic work x-ray therapy equipment has been installed and is being used. Freddy Fagan is a Norwich boy and we in Norwich are justly proud of his progress.

Dr. Hilliard Spitz has recently opened his office for the practice of cardiology and internal medicine. Best wishes for success.

The annual outing of the New London Medical Society was held at Edgemere Manor in Stonington on Wednesday, August 1. 74 persons attended and from all reports the affair was quite a success. The caddies found many golf balls and the fish had a day of rest.

The Connecticut Cancer Information Center has been established at the Lawrence-Memorial Hospital with Mrs. Mary Guenther as director.

The new Blood Bank, donated by the B.P.O.E., is practically completed at the W. W. Backus Hospital, Norwich and will soon be functioning. This will be quite an addition to the rapidly growing efficiency of the hospital.

Dr. Richard Newcombe of Windham is now associated with Dr. Kenneth K. Kinney in the practice of radiology. Dr. Newcombe is a graduate of the University of Vermont, served 4½ years in the armed forces, reaching the rank of Lt. Colonel. He served a fellowship at the Lahey Clinic in radiology. The W. W. Backus Hospital is fortunate in having Dr. Newcombe joining with Dr. Kinney in rounding out a most efficient X-ray Department, both as to diagnosis and therapy.

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NEW BOOKS IN REVIEW

SUCCESSFUL MARRIAGE. Edited by Morris Fishbein, M.D., Editor, *Journal of the American Medical Association* and *Hygeia, the Health Magazine* and *Ernest W. Burgess*, PH.D., Professor and Chairman, Department of Sociology, University of Chicgao. *New York: Doubleday & Company, Inc.* 1947. 547 pp.

Reviewed by STANLEY B. WELD

The editors have amassed an immense amount of material in this volume, in fact, if there is to be any criticism of this book at all it is in its size. In this day of 1,000 page novels this may not be a valid criticism. We have come a long way from the hush-hush attitude toward the private problems of married life of 50 years ago and well we may with our divorce rate climbing by leaps and bounds.

This volume is divided into 5 parts dealing with the following phases: preparation for marriage; the marriage; conception, pregnancy, and childbirth; the child in the family; social problems of sex and marriage. Each phase of married life is dealt with in a series of chapters, each by different individuals, usually a PH.D. or an M.D. In Part One a chapter is devoted to the marriage counselor and all through the book this individual is frequently referred to. A new vocation, marriage counseling is coming to play a valuable role in helping the couple in their preparations for marriage as well as advising them of the best solution of difficulties that arise after marriage. To many young couples the knowledge that this assistance is available, at least in the larger centers of population, will come as a welcome surprise. Recent college graduates and particularly those who have been students of sociology will have learned of the marriage counselor.

Part Two, The Marriage, presents an excellent discussion of subjects of vital importance to the newlyweds. No punches are pulled. Sex is discussed frankly and in detail. There is included an excellent chapter on Home Management and Finance by a professor of economics. The chapter on abortion is an exceedingly valuable one if we are to educate our young women in the evils of this procedure when carried out illegally. It is doubtful if the average reader will benefit much by a recital of the therapy of threatened abortion as given by Dr. Guttmacher.

Part Three, Conception, Pregnancy, and Childbirth, contributes considerable factual data, valuable to the young couple as a reference if not too interesting reading. The next section devoted to the child covers a large field. The discussions of adoption, of the stepchild problem, of masturbation, and of juvenile delinquency are excellent. This section will bear much study by our youthful parents as they probably have received little instruction in this field in their own homes. One of the crying needs of the modern home is more education of the parents, and in particular of the mother, in the problems of child training. The emphasis on the family council discussed by Professor Bossard in the closing chapter of this section is very timely.

The final section of the book contains a discussion of various problems. The chapter on divorce is concise and informative. Dr. Werner in his discussion of the climacteric goes into details of treatment which might better be left to the physician. The public already is becoming overhormone conscious. Emily Mudd's closing appeal for "not men *or* women" in our world today, "most certainly not men *against* women, but rather men *and* women together shouldering the load" well expresses the theme of this entire volume.

It is a readable book, so divided that it may be taken up at random or used as a reference for some particular phase of the subject. Many of the chapters carry reference notes at the end and some have a bibliography. The introduction is written by the secretary of the American Association of Marriage Counselors and the preface by Dr. Fishbein. The book is probably the first of its kind published. The editors have done an excellent job in keeping it free from the use of too many statistics.

TREATMENT OF HEART DISEASE. By William A. Brams, M.S., M.D., PH.D., Associate Professor of Medicine, Northwestern University Medical School, and Attending Physician, Michael Reese Hospital, Chicago. *Philadelphia and London: W. B. Saunders Company.* 1948. 195 pp. with 11 illustrations. $3.50.

Reviewed by PAUL H. TWADDLE

This small book is intended for the general practitioner and medical student as a guide to the treatment of heart disease. No attempt is made to include discussions of diagnosis, etiology or pathology which may be obtained from other standard texts. The first section of the book deals with the Pharmacological Action of Drugs used in the treatment of heart disease, including important data on quinidine, mercurials, xanthines, oxygen, hypnotics, sedatives and digitalis and its related drugs. A basic understanding of these agents is helpful in proper application in any specific case. The remainder of the book covers the therapy indicated in congestive heart failure, in specific diseases involving the heart, in arhythmias, conduction defects, metabolic disturbances, deficiency states and certain functional states. A final chapter discusses Surgery and Heart Disease from the viewpoints of operative risk, anesthesia, management of congestive failure and other disturbances and the risk of parenteral fluids. Throughout a plan of treatment is offered which it is considered will serve as a guide in handling the majority of cases. There are 290 references to the literature in the bibliography.

In many texts on cardiology emphasis on treatment is secondary to the discussion of etiology, diagnosis and pathology. This book, with its limited scope, its brief but adequate presentation is considered a valuable aid as a reference and a source of information from the author's experinece. The suggestions as to therapy are practical, clearly expressed and lengthy discussions of controversial methods of treatment are avoided. There is little occasion to disagree with the subject matter and there are a good number of helpful aids which the author offers from his own experience.

The reviewer is of the opinion that this book will be favorably received and of assistance to its reader.

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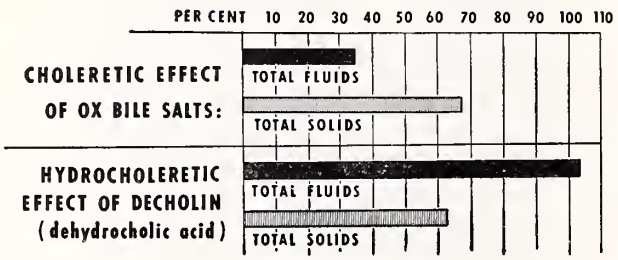
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PSYCHOBIOLOGY AND PSYCHIATRY. (Second edition.) *By Wendell Muncie*, M.D., Practicing Psychiatrist; Chairman, Medical Advisory Board, Seton Institute, Baltimore, Md.; Associate Professor of Psychiatry, Johns Hopkins University; Consultant in Psychiatry, U.S.V.A. *St. Louis: The C. V. Mosby Company.* 1948. 620 pp. with 70 illus. $9.

Reviewed by Louis H. Gold

Dr. Muncie needs no introduction to the great body of psychiatrists in this country and abroad. To many others he also is well known as a brilliant student and teacher. With Adolf Meyer he has done much to develop the clear thinking and vision which characterize American psychiatry.

In the preface to the 2nd edition Dr. Muncie states: "There is still too much heat and too little light in our discussions. Case observation leads to generalization, generalization to rigid systematization, systematization to belief, and belief to intolerance, and intolerance to ambition to control teaching policy and the few facilities for hospital treatment. At a time when many methods may demonstrably produce helpful results, how utterly shortsighted for traditionalists to deny the usefulness of psychoanalysis, for psychoanalysts to refuse to accept the usefulness of shock therapy, and all together to condemn prefrontal lobotomy! Is our primary task to aid human sufferers or to remain faithful to our several scientific heritages with all their attendant defects?"

This book is in every sense a text. There are 3 parts divided into 29 chapters Part I deals with Psychobiology—The Study of Normal Behavior. It describes the student's personality study and is full of important psychiatric data tests and concepts. The conclusions on p. 134 hold such appeal that they will bear reading several times Part II describes Abnormal Behavior—Pathology and Psychiatry Part III discusses Treatment The material on pp 515-52 should be prescribed reading for every practicing psychiatrist Here are presented the author's thoughts on The Therapeutic Situation. The Patient and His Part in Treatment, The Physician and His Task, How The Physician Works and Formulation of Material.

There are 228 excellent references which should be valuable for supplementary reading This book is recommended without qualification to all who are interested in human behavior.

VOLUNTARY MEDICAL CARE INSURANCE IN THE UNITED STATES. By Franz Goldmann, M.D., Associate Professor of Medical Care, Harvard School of Public Health; Lecturer, Yale School of Medicine, Department of Public Health. *New York: Columbia University Press.* 1948. 228 pp. $3.

Reviewed by Stanley B. Weld

Dr. Goldman presents an estimable and quite thorough survey of the development of voluntary medical care insurance plans in this country. His figures are taken from reports of various plans presenting data through 1946. The longest chapter in the book is devoted to the author's favorite plan for medical care, group practice. He has written on this subject before, notably in "Public Medical Care" reviewed in *The Journal*,* and in "Potentialities of Group Practice of Medicine" published in *The Journal*.†

*Vol. IX, No. 9, Oct. 1945
†Vol. X, No. 4, April 1946

After reviewing the development of voluntary medical care plans, including cash indemnity plans, service plans, Blue Cross, Blue Shield, individual plans, and group practice plans, Dr. Goldman in the closing chapter calls the reader's attention to the similarity of the growth of these plans in the United States in this century with those in European countries in the second half of the nineteenth century. He offers 14 basic questions, the answers to which are necessary for the proper appraisal of voluntary plans. He points out that "adoption of a prepayment plan without simultaneous organization of professional and institutional services meeting high standards and without building a suitable and efficient administration merely perpetuates old evils."

The hope of voluntary medical care insurance, as Dr. Goldmann sees it, lies in a combination of group prepayment and group practice and in the inclusion of comprehensive professional services and hospital care in one plan. Whether or not one agrees with all the author's conclusions, the book contains much valuable information. It should aid the individual physician in gaining a better concept of the entire problem and in arriving at his own conclusions at a time when a prepaid medical care plan in Connecticut is being formulated.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. (Twenty-first Edition.) *By W. A. Newman Dorland*, A.M., M.D., F.A.C.S., Lieut.-Colonel, M. R. C., U. S. Army. *With the Collaboration of E. C. L. Miller*, M.D., Medical College of Virginia. *Philadelphia and London: W. B. Saunders Company.* 1947. 1660 pp. 880 illustrations including 233 portraits. $7.50.

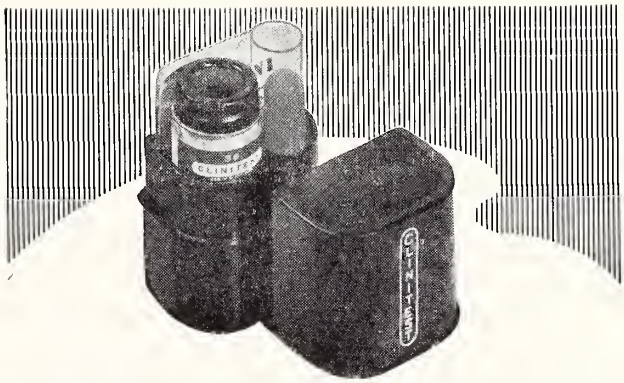
Reviewed by STANLEY B. WELD

The editor of this best known, most widely used medical dictionary again has produced a volume of the finest quality. Since the preceding volume was published three years ago the results of medical progress in World War II have become evident in a voluminous number of additions to medical terminology. These additions have been covered as completely as possible and are not confined to the field of actual war medicine and surgery but include many of the specialties, such as tropical medicine, aviation medicine, physics and nucleonics.

The volume is as valuable as its predecessors. The illustrations are for the most part small but excellent, but in addition there are many full page colored as well as black and white cuts. The type is clear, the binding flexible, and the useful thumb index is present to aid the reader. The only additions to the dictionary of words and indices are a Greek alphabet in the front of the edition and a Table of Doses with both apothecaries' and metric systems in the back.

SOUTH ATLANTIC ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

The South Atlantic Association of Obstetricians and Gynecologists announces the establishment of "The Foundation Prize." Authors of papers on obstetrical or gynecological subjects desiring to compete for the prize may obtain information from Dr. E. D. Colvin, secretary-treasurer, 1259 Clifton Road, N. E., Atlanta, Ga.



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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The Connecticut State Medical Journal

Has made arrangements through its Journal to secure MEDICINE OF THE YEAR for those of its members who wish to subscribe. MEDICINE OF THE YEAR is an annual review of medical progress which will appear as a supplement to the Journal early in 1949. It will be a descriptive and analytical account of progress in medical science and practice during the preceding year presented in a practical, useful, and informative manner, particularly as it relates to the everyday practice of general medicine and the specialties.

The editorial management is under the direction of Dr. John B. Youmans, Dean, College of Medicine, University of Illinois. The principal contributors and their subjects are the following well-known medical educators and writers:

Internal Medicine—Dr. Hugh J. Morgan, *Professor of Medicine, Vanderbilt University, Nashville, Tennessee.*

Obstetrics—Dr. Frank Whitacre, *Professor of Obstetrics and Gynecology, Memphis, Tennessee.*

Pediatrics—Dr. Henry G. Poncher, *Professor of Pediartics, University of Ilinois, Chicago, Illinois.*

Surgery—Dr. Warren H. Cole, *Professor of Surgery, University of Illinois, Chicago, Illinois.*

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This annual review of medical progress is being offered to members of state medical societies and subscribers to state medical journals. Of the subscription price your Association will retain a part to defray any costs associated with the announcement of this service and the handling of subscriptions. In order to secure this service, subscriptions from approximately one-third of our members and subscribers is required. Because of the short time available, subscriptions must be entered promptly. DO NOT DELAY. Send in the coupon below, or write directly, sending check or money order. If an insufficient number of subscriptions is obtained, no obligation will be incurred and your money will be refunded. ACT NOW.

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The
CONNECTICUT STATE MEDICAL JOURNAL

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THE MANAGEMENT OF ACUTE CORONARY THROMBOSIS AND ITS COMPLICATIONS

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THE difference between treating meningococcus meningitis properly and improperly is tremendous. The difference between treating acute coronary thrombosis and its complications properly, or as well as we can, and not treating them particularly well, is not very great. The great majority of patients with acute coronary thrombosis will recover from that particular episode or die, independent of what we do. Our therapy, therefore, is directed at a small percentage of individuals. It is a small but not terribly small return we get for the intelligent care of acute coronary thrombosis. We should start with that point of view. We all have seen patients have acute coronary thrombosis and actually work through it, recover without seeing a doctor, and we have also seen many patients with coronary thrombosis who have recovered and have done well with half-hearted treatment. They may refuse to abide by our decision and merely take it easy for a while and recover quite satisfactorily. We therefore must not be too harsh with the other fellow who does things a little bit differently from what the text books may say.

What is our routine, the routine that I plan to discuss here? The first thing we all do is to give morphia for the pain, or some other similar narcotic. How much you give, or how you give it, will depend upon your own experience; a quarter of a grain—sometimes a lot more—sometimes you wish you had given even a little bit less than that quarter of a grain—sometimes it makes them so sick for six to twelve hours afterwards that they are vomiting when they might have been spared that discomfort. However, it is a routine that I think is worth while following. Occasionally you may think you want to give the morphia intravenously. I do not like intraveneous medication in acute coronary thrombosis in general. However, I do not have the same fear about morphia intravenously, or saline intraveneously, (comparatively innocuous preparations) as I have of some other chemicals intravenously. There is something about an intravenous injection to a person who has coronary artery disease that may "explode in your face." If you do much of it, someday you will give an intravenous medication to a coronary patient who will be dead in two minutes, and you will not be able to say that it was an accidental death. When anything like that occurs, you had better blame the thing you did. I do not think that the drugs that have caused sudden death in these coronary cases when given intravenously have a specific effect, i.e. that one preparation will do it because it has mercury in it, or another because it contains aminophylline. I think there is a generic principle involved; something trips the heart and it stops. I have seen it occur with caffeine, mercury, aminophylline, and arsenic intravenously, and when it is given by yourself it is quite a shock.

Once in a while a patient will suddenly collapse and is pulseless at the start. There is no pulse and the blood pressure is zero though the heart is beating. In some cases this can be a temporary affair but you do not like to have anyone remain pulseless for a long period of time. I think it is useful at that time to give some adrenalin subcutaneously. Once in a while this does something to the pressure so that the pulse comes back, there is some pres-

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sure, and the patient at least lives long enough to go through the acute coronary thrombosis, afterwards, and may recover.

Rest in Bed. There has been something holy about the term "rest in bed." It has been sanctified as if it must never be questioned. Well, it deserves some questioning. If a patient is comfortable, can lie flat with comfort, I imagine that no harm is done by rest in bed, and it may be easier for nurses to look after the patient. But when the patient has marked dyspnea it becomes very questionable whether he is better off in bed. There is reason to believe that a heart is often worse, has a greater burden, with the patient in bed than if he were out of bed in a chair. Of the few things I am certain about in the treatment of acute coronary thrombosis, I am sure that I have saved a few lives by getting coronary cases out of bed, putting them into a chair, and letting their feet hang down. When a patient is in that position the heart is resting more than if he is lying flat. We are trying to afford rest to the affected part. The heart that is injured or that shows evidence of left ventricular failure with pulmonary edema and congestion works less with a patient in this position than when recumbent. There is less return flow. You are performing a phlebotomy in keeping blood down in the lower part of the body where it does no harm rather than having it surging back to the lungs where it suffocates the patient. You will see some cases of acute coronary thrombosis who are gasping for breath with pulmonary edema, who will feel better and breathe better even a few hours after you get them out of bed and put them into a chair with the feet down. I feel certain there are a few people who owe their lives to me because I have had enough sense to take them out of bed and put them into a chair.

Now as to the length of time we keep patients in bed when acute pulmonary edema or pulmonary congestion is not a threat. If there is no breathlessness, being in bed in a comfortable position is quite all right. How long should we keep such a patient in bed? It used to be six weeks no matter how mild the illness was. Now I think a good many can get out of bed in three weeks. Some of them, of course, will need a longer period. That will be apparent to the doctor who sees the patient and sees how he looks, the course he has run, etc. I think he deserves at least three weeks of rest either in bed or in a chair.

During the early days oxygen may be helpfu Usually a patient ought to know that it makes hi feel better. If he is conscious and alert, the patie who is being helped by oxygen generally fee better taking the oxygen, and if he keeps insistin that he does not or would rather be out of th tent, it is very doubtful whether it is doing hi any good. I am not sure that it is helpful for th pain, although at times it would seem that the pai is also lessened by breathing oxygen liberally wit a mask or a tent. Now as to fluids—I think the need more fluids than we used to give them, eithe by mouth or intravenously. This is particularl indicated if they are dehydrated, and have a dr tongue. I would give them a slow drip of 3 or per cent glucose intravenously if there is no pul monary edema.

Most patients with acute coronary thrombosi have pulmonary congestion. If you take routin x-rays in acute coronary thrombosis almost all wil show pulmonary congestion. They have conges tion when they have no rales. That is a frequen experience in cardiac disease. Congestion occurs i the lungs long before we hear moisture in th alveolae. When you follow any cardiac and breath lessness develops, the vital capacity of the lungs i decreased before you ever hear any rales, and als these patients show pulmonary congestion on x-ra when you hear no abnormal respiring sounds. Pul monary congestion should make you cautious abou intravenous fluids. I might mention one word abou the use of plasma. I think occasionally plasma in travenously for the severe shock state is life sav ing. You have two types of heart failure going on central and peripheral, pulmonary congestion or the one hand and peripheral shock on the other Sometimes both are present and we are trapped medically, or therapeutically. There are some case that are in severe shock, but have little if any dyspnea. I mean a person who is practically pulse less, or has no blood pressure reading whatever, or may stay with a pressure of 60 mm. for hours at a time. When the low pressure of that degree lasts a long time they develop an irreversible state and do not get out of it. If such a patient has no dyspnea, is lying flat, and has no obvious rales, and is in peripheral shock, and stays so for more than an hour or two, I think plasma is worth a good deal. In some of them it is actually a life saving measure. I have had an experience like that where the pressure was zero and had stayed that way. The heart was beating and the patient was lying per-

fectly flat. Five hundred cc. of plasma brought that patient right back and he lived long enough to go through the whole course of acute coronary thrombosis and recovered. There is a recent paper on the subject in the *American Heart Journal* where even 2000 cc. of plasma was given.

Now let us consider a few of the complications that require specific therapy. Once in a while patients start having Adams-Stokes attacks and they can die in one of these attacks when the heart entirely stops. They have heart block, the heart goes into asystole every once in a while and they may have frequent attacks. I have seen instances where the attacks were coming almost all the time, even every few minutes. Such a patient should receive adrenalin, for I have no fear of giving adrenalin to an acute coronary when this threat confronts us. You may give adrenalin even by the clock—.3 to .5 cc. of 1 to 1000 solution every two hours for forty-eight hours, provided you see it is helpful. It is not of much value for the slow heart rate of 35 or 40 itself. Adrenalin is given for the tendency to asystole and syncope, not for the slow rate. You may find that after a day or two the tendency to cardiac arrest is gone and then you can stop the adrenalin. Almost all patients who show this complication of Adams-Stokes disease with acute coronary thrombosis and recover, get over the heart block. It is rather rare to have them stay permanently in complete block at that time. They may develop block later on, but with recovery of the acute illness complete block disappears and they end up always in a lower degree of block. If they had third degree block, they end up with a first degree block and a slight delay in conduction or none at all. If they had second degree block they get over that. You are treating a temporary emergency from which the patient is likely to recover if he can live through those early days.

Another complication that is challenging is when the reverse occurs. The heart suddenly becomes rapid, 180 to 240, with tachycardia of the ventricle. A few of those, when left alone, revert normally but from what I have seen, most of them do not. A tachycardia of the ventricle can come in two to three per cent of the cases and most of those can be treated effectively. Quinidine is the best medication. Whether you are going to give quinidine by mouth or give it intravenously is a matter of judgment. We prefer to give it by mouth, for as I indicated before I do not like to give intravenous medication if it can be avoided. Mouth therapy takes a longer time to work You do not know what dose is going to be needed, and the technique that I think is reasonable is to give a certain dose, .2 or .3 grams orally, unless the condition is imminent and minutes are precious. You wait a few hours and if nothing has happened increase the dose to .4 or .6. We have gone up to as high as 1.5 grams. That is a huge dose but we had no choice. One cannot dogmatize about using intravenous medication. If the case is difficult to control, or the situation is very urgent, the intravenous method is indicated. In the past several years we have had no fatalities except in one of our early cases. This patient died in two minutes. The tachycardia stopped but the heart did not start beating. It was given more rapidly than it should have been given. You can give quinidine intravenously in 100-200 cc. of 5 per cent dextrose, spending a half hour or an hour doing it. Now that we have the necessary apparatus, we can watch the heart rate. While giving the injection we can have the patient wired and actually see the beat with the cardiograph going. You will know you have a quinidine effect because the heart will generally slow while the effect is going on until it reverts into normal rhythm. You may need .3 or .6 grams intravenously, given slowly, to make the rhythm return to normal. I feel sure that we have taken a few people out of their graves by such intravenous medication.

Magnesium sulfate intravenously occasionally stops a tachycardia of the ventricle. This should also be given slowly, and it also has the same hazard. The dose is 2 to 4 grams. It does not seem to work as effectively in my hands, at least, as quinidine. In some instances magnesium sulfate failed when quinidine stopped the attack satisfactorily. I remember a patient whose heart rate was 240, and he was as cold as a cadaver with no pulse, unconscious, blood pressure zero, and it was two o'clock in the morning. Everyone felt low-spirited, I did. The experience eventually proved thrilling. The creditable part I played in this drama was that I was at least able to pierce that vein. It was no simple matter when there was no blood pressure. The quinidine was given slowly, and you could watch the heart rate just come right down like a nose dive to 80. The pulse and color returned and the patient recovered. It is satisfying to talk about

the few people you do something for because with so many of them, as I stated at the beginning, no matter what you do they succumb or recover.

A new approach in the treatment of acute coronary thrombosis is going on right now—the use of anticoagulants routinely. I am in no position to give you any statement, or certainly any final statement about that. Theoretically there is some justification for their use. In about two or three years I think we may know the answer. I have a distinct impression that intelligent anticoagulent therapy as a routine procedure for acute coronary thrombosis will lower the mortality. Men in various centers are embarked on this project, using alternate cases. This is the only method of finding out what the mortality of the two groups will be. It is not the cure-all that the first reports might have made one believe; we have had fatalities with dicumarol, and we have even seen the thromboses in the ventricle at autopsy which we were trying to prevent. We have not always prevented the very thing that anticoagulant therapy was meant to effect. It is a troublesome job, requiring daily prothrombin time determinations. However, it is no bigger than we would want to do if we can reduce the mortality in acute coronary thrombosis. The idea is to diminish the incidence of secondary thrombosis within the cavities of the heart, and also to prevent thrombophlebitis in the legs that so commonly occurs in any cardiac who is at rest. I suspect that the overall mortality is going to be decreased, but how much I do not know.

Digitalis—That is a troublesome question. It is very annoying to bring that question up in the treatment of acute coronary thrombosis, and the worst of it is that we have been talking about it for 25 years and do not know the answer. Should you use digitalis? Is it ever of use? I can tell you why it is debatable. Digitalis is good for what we call congestive heart failure, but it is often poor medication for peripheral shock. If a person is in shock and you give digitalis that heart is a little worse for it. In acute coronary thrombosis both types of heart failure may be present, central and peripheral failure. You can see that therapy will be quite conflicting and antagonistic. You may do a phlebotomy for heart failure with pulmonary congestion. This would be the very worst thing to do for peripheral failure. You would transfuse for peripheral shock which would be bad for pulmonary congestion. You would give digitalis for a congestive heart failure but would not for peripheral failure. Even its use in auricular fibrillati has been questioned by one observer who publish some papers in which he concluded that digital even in the fibrillators with acute coronary thro bosis, was harmful and increased the mortality. is hard for me to accept that. We should keep open mind about this problem. I must confess th once in a while I give digitalis, but I do not it with any certainty. If there is increasing dyspno and the patient is not cold and wet, has not mu peripheral shock, I may give it. I rarely kno whether I have accomplished anything, but I gi it. It is very difficult to appraise the value therapy. There are many other things going o the patient recovers and it is hard to know wh was the decisive factor and that is why the alterna case method is the only answer. No such stu concerning digitalis has been published as far I know.

Having spoken about giving plasma for the sho state, the reverse is applicable. There are occ sional cases where phlebotomy has been helpf I feel sure of it. I do not know how I can form late a basis for its use. Sometimes you do the things because you do not know what else to d The patient is getting worse and you may wa to do something that appears logical. I recall patient who was having increasing dyspnea and great many rales. Day after day we were in quandary whether to give him plasma for the sho state or to bleed him because he had pulmonar edema. Finally I could not bear the indecision an longer and I said "Let's try one or the other—let bleed him." We bled him and he promptly in proved. There was a very dramatic change withi an hour or two, and from then on he recovere That appeared to be decisive in the turn of event

One word is appropriate about rehabilitation. think patients spend too long a time in the trea ment of acute coronary thrombosis. Some peop lose their jobs permanently; they never get bac to work because someone was free in telling the to take three to six months off. They are turne into social derelicts when six weeks might hav been sufficient. It is very doubtful whether a patie would eventually live any longer having taken si months off than he would have lived if he had take six weeks off. It certainly would have been bett for his family, for his social status, if he had bee back to work sooner and supported himself. think the medical profession has been a bit to generous in handing out sentences like—"take si

nonths off." It means no financial income unless person has plenty of means. Time is precious, nd life is short anyway. To spend three months nore for a doubtful gain and have the patient's mily suffer is open to grave question. In general seems to me that we should have our patients ack to part-time or full-time duty sooner than is astomarily carried out.

The main points of this discussion are that the treatment of some of the complications of acute coronary thrombosis may be very effective and occasionally life saving, that anticoagulant therapy is promising and that patients with acute coronary thrombosis may frequently be rehabilitated and returned to some useful occupation sooner than is often practiced.

INTEGRATION OF ANESTHESIOLOGY IN MEDICINE

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A relatively new specialty has blossomed forth in medicine and is encountering "growing ains," trials and difficulties. Anesthesiology has assed through the infant age and may be correctly esignated now as being adolescent. In one sense e may even regard its development as precocious. he late war has made the specialty conspicuous, no previous sequence of events or episodes have one so. The statement that anesthesiology is "over ld" is probably true. At the moment qualified nesthesiologists are in great demand and there are ot enough of them to supply the demand, let alone e minimum needs or requirements of hospitals in is country.

At the moment several problems present themlves. Certain localities need and are requesting ofessional anesthesiologists and we cannot supply e necessary number of qualified individuals. econdly, we have the task of demonstrating and nvincing some medical groups the benefits to gained by having the professional service and sistance of qualified anesthesiologists.

In order to partially fulfill the demands for prossional anesthesiology, we can say that there are me 200 approved residencies for training in this ecialty. In a few years hence there should be a finite improvement as far as the supply of anesesiologists is concerned. We need more residencies, however, and they should be created as rapidly as possible whenever possible. The incentive and stimulus to pursue this specialty must revert back to medical school teaching, if a reasonable supply of doctors is to be had to continue the program. Medical school curricula should incorporate lectures on anesthesiology to indicate the close cooperation between surgery, medicine and anesthesia.

In answer to the second task which anesthesiology is encountering we can point out certain facts. No less than 45 million people in this country are covered today by voluntary, commercial and industrial types of hospital insurance. It is being recognized that hospital care is becoming rapidly one of the normal necessities of life. An institution to which so many scores of millions of Americans look to as a basic necessity will have to account to public opinion for the manner in which it is to be operated and for the quality of the service it renders. When considering a breakdown of hospital admissions we find that 60-65 per cent of them are surgical or obstetrical. It should be clear without going into too much detail, at this moment, that anesthesiology service directly affects the welfare and safety of 60-65 per cent of hospital admissions.

What does the professional anesthesiologist do for surgery, medicine and in a more coordinated sense the hospital surgical service? The previous 100 years can be designated as the century of painless surgery. Currently we are engaged and entering into an era of safer surgery.

esented at the 156th Annual Meeting of the Connecticut State Medical Society, Fairfield, April 28, 1948

Initially the first survey the professional anesthesiologist undertakes is to individualize the patient. There is no routine or set formula with respect to the choice of anesthetic agents and methods. Inasmuch as all anesthetic agents are lethal drugs in certain doses, an agent that can be used safely on one patient may jeopardize the life of another. The anesthesiologist must be qualified to determine the safest agent and method for the particular patient. At this juncture the teamwork of the surgeon, medical consultant and anesthesiologist is most important. Any and all information should be available concerning the individual patient. Many times the original medical consultant and surgeon have pertinent information which should be made known to the anesthesiologist. When all of the medical and surgical data obtainable are known, the anesthesiologist with his intensive training in the pharmacology and physiology of anesthetic agents and clinical application of these same agents, is best able to determine the choice of anesthesia.

The problems of surgical complications do not originate necessarily on the operating table. Frequently they may begin before the patient reaches the operating room, depending upon the pathology present. Before the premedication is administered the total problem must be projected on the principle of "balanced anesthesia," and that principle cannot be applied except in the specific terms of the individual and individualized patient.

With the whole pattern of the premedication, the anesthesia, and the anesthetic technique having been predetermined by an evaluation of what the particular patient will best tolerate, and with the anesthesiologist providing further supportive care to assure continued safe tolerance by the patient of both the anesthesia and surgery, the surgeon is not forced to perform surgery hastily.

Upon the completion of surgery the responsibility of the professional anesthesiologist to the patient continues until the latter has recovered from anesthesia and for an additional period of time, depending upon the individual surgical condition. The well trained anesthesiologist should also be responsible for blood transfusions in the operating room, special forms of intravenous therapy and artificial respiration. In some situations the anesthesiologist may operate a "blood bank." In the obstetrical field he must know the procedure of infant resuscitation, as well as every type of analgesia and anesthesia during labor. A reasonab broad medical background is necessary to enab him to establish routines of close cooperation, research and in experimental as well as clinical fun tions with the other hospital departments. In ge eral medicine he should manage difficult intraveno therapy, diagnostic and therapeutic nerve bloc and special sedation problems. Postoperative su tion bronchoscopy should be done by the ane thesiologist when the occasion arises. He must wo with the pathologist in maintaining a systemat check on the role of anesthesia in all operati deaths. Finally, all of the services that an anesthes ologist is to provide must be maintained on a hour emergency basis. An anesthesiology servi similiar to that which has been outlined goes far raising the standard of surgical and medical pra tices in a community.

During the past year the popular press has ca ried a number of articles referable to the specialt anesthesiology. In some instances the impression th has been conveyed by certain presentations has n been entirely to the credit of this specialty, whi in others a true representation of the compositio of this specialty has been portrayed in a mann which the lay public can easily understand. Le there be any misinterpretation, let me say that th main concern of an anesthesiologist is the patie and the surgery to be accomplished. The patie comes to a hospital for surgery—not anesthesia. is a ridiculous idea to imply that anesthesia supe sedes surgery. The role of the anesthesiologist and should continue to be supportive and compl mentary to surgery.

ECONOMICS OF ANESTHESIOLOGY

For the physician who has just the time, effor and money to educate himself in this specialty, remunerative program commensurate with phys cians in other specialties with equal training an ability should be available. The dollar and cents sid of anesthesia varies with the type of anesthesiolog practice. The private fee anesthesiologist proble is usually less complicated than the problem of th individual who heads a hospital anesthesiolog service. In a hospital practice no professional anes thesiologist wants his department to be supporte by income from other departments. On the othe hand, the earnings of the anesthesia departmen should not be used to make up hospital deficit resulting from inefficient handling of other depart ments.

It has been very clearly stated in an article on dministrative and professional problems of med- al practice in hospitals by a well known medical chool dean, that certain specialties are intimately ssociated with a dilemma which is not necessarily nchallenged, but more exactly unresolved. A uoted paragraph from this article seems to me to e timely:

"It cannot be denied that the functions of the ospital pathologist, the laboratory physician, the hysician anesthetist, the physiotherapist, and the adiologist belong essentially to the area of med- al practice. As such, these medical specialists are ubject to the same ethical requirements as are the nternist or the surgeon, the obstetrician or the phthalmologist. Their work is essentially to be egarded as a professional service to the individual atient; their work should be carried out strictly n the spirit of the personal relationship between hysician and patient; there should be interposed n that relationship no third party. The service hould not rest upon considerations of financial eturn but solely, according to the very first prin- iple of ethical practice, upon the need of the atient for medical services. If any of these physi- ians enter into contractual relationships with an rganization or institution, they, like all other hysicians, the general practitioner as well as the pecialists, must safeguard the ethical character of hat contract. These 5 groups of specialists giving eneral hospital care must be just as careful and onscientious in their avoidance of fee spliting as he surgeon and the surgical specialist is required o be. All of this and all that is implied in it and ll that might be said in amplification is all theo- etically sound and basically true."

"There can be no doubt about the validity of the principle enunciated in the resolutions of the House of Delegates and of several reference committees of the House in the American Medical Association when they assert that the practice of the pathologist, of the radiologist, and of others whom we have so often mentioned in these remarks is essentially the practice of medicine."

Patients should be charged for anesthesia, and it should be indicated that it is a medical fee they are paying and not a fee for a technical hospital service. Experience has already shown beyond all doubt that patients are willing to be charged for anesthesia once it is explained to them that the anesthesia is administered by a professional anesthesiologist.

If, with the gradual development of contracts to help the patient carry the load of unexpected medical care, anesthesiology may be included along with surgery and obstetrics as a component of the overall pattern of prepaid medical service, not hospitalization. These contractual agreements are in the main designed to assist those individuals with modest fixed incomes. The persons with incomes above a certain level may be subject to charges over and above those limitations set by certain contracts. In general, a subscriber's contract for hospitalization benefits should exclude all medical professional services.

While the overall cost of medical care is giving the lay public concern, it would be a serious mistake to construe this concern as indicating a drive for bargain basement medicine. And lastly, anesthesiology which today is assuredly becoming a definite medical entity capable of providing greater possibilities in surgery, and above all promoting safer surgery for the patient, should not be included in any prepaid hospitalization service.

CLINICOPATHOLOGICAL CONFERENCE

THE WATERBURY HOSPITAL STAFF

JOSEPH O. COLLINS, M.D., Editor, *Waterbury*

A 49 year old male farm laborer was admitted complaining of vague recurrent aches and pains in the muscles of his arms and legs, prickling sensations in his fingers, ready fatiguability and general malaise for a period of several months. His employer had told him that he "didn't act right" and that he "was slipping." His friends had told him that he "didn't look right" and that his "lower lids were swollen and baggy." The aches in the extremities seemed to be confined to the muscle group. In the legs, it seemed to start in the lower legs and spread up to the hip and groin. At first, the aches were not severe, but they gradually increased in severity until, at the time of admission, there had been a constant ache in the legs and arms for several weeks. At times his arms seemed swollen. He has had some abdominal pains and some spells of nausea without vomiting. The ache in his arms is increased by milking the cows on the farm or by driving a car, and at such times his hands became quite numb. He sometimes awakens at night with a similar numbness in his arms and legs. He visited a physician about three weeks before admission when his symptoms became worse. The doctor prescribed some medicine and recommended that his teeth be pulled. This was done without benefit to the patient.

Past History: Non contributory. Patient claims he was always strong and well until the present illness.

Family History: Father died at 76 of cancer. Mother dead—cause unknown. Four siblings living and well. Wife and four children living and well.

Physical Examination: Temperature 98. Pulse 70. Respirations 20. B.P. 114/84. Patient was a well developed and well nourished male. Skin on the backs of the hands was thick, chapped and fissured. There was bilateral frontal alopecia. Hair was gray, dry and coarse. There was slight puffiness of the eyelids. Pupils reacted normally to light and accommodation. Face looked puffy and lips were thick. Few small discrete lymphnodes were palpable in the neck and axillae. The thyroid was not palpable. Heart sounds were distant. PMI was neither seen nor felt. Heart was not enlarged to percussion. Abdomen was negative. There was very slight pitting, pretibial edema bilaterally. There was no muscle tenderness in either upper or lower extremities. Reflexes were normal.

Laboratory Data: Urinalysis showed sp. gr. 1.014, albumin negative, sugar negative, and occasional wbc. Blood count showed hgb. 12.3 gms, rbc 4,160,000, wbc of 8,300 with 58 per cent polys, 24 per cent lymphs and 6 per cent eosinophiles. Kahn was negative. Repeated Wbc showed only 1 per cent eosinophiles three days later.

Progress in the Hospital: While in the hospital, the patient had some frequency of urination and nocturia once nightly. Patient was given sodium salicylate four times daily while in the hospital and on the third day was allowed out of bed. Patient seemed "peppier" when discharged on the fifth hospital day.

Second Admission: Three days later.

Interval History: On the day following discharge, the patient complained of cough. Rales were heard over the whole chest and a bottle of cough syrup containing three grains of codeine sulphate was left for the patient to take. The patient remained afebrile but that evening he became suddenly irrational. He was finally put to bed where he was found unconscious the next morning. The contents of the bottle were gone, but it was not known whether it was taken by the patient or accidently spilled.

Physical Findings: The patient was admitted to the hospital in a comatose condition. Temperature 99.3. Pulse 80. Respirations 22. Face and arms were cyanotic. Breathing was labored. Pulse weak. Extremities were cold and clammy. The chest was filled with coarse rales. Pupils were in mid dilatation and reacted slightly to light. Conjunctival reflexes were strongly positive. B.P. 150/90.

Laboratory Data: Urine showed two plus albumin, negative for sugar, negative for acetone. Blood sugar 119, NPN 48 mg. per cent.

Progress in Hospital: Patient was placed in an oxygen tent and received the following medication:

Metrazol	1 cc. intravenously
	1 cc. subcutaneously
Cortate	2 cc. intramuscularly
Sorbital	50 cc. of 50 per cent solution plus 20 cc. of aminophylline intravenously

Under treatment, the patient regained consciousness, opened his eyes and responded to questioning. He states that he felt well. However, he seemed tired and his respirations were still rapid and labored. Improvement was of short duration. Patient became irrational. He became progressively more dyspneic in spite of the digifolin and caffeine. Pulse rose from 80 to 120, respirations from 22 to 35, and temperature from 99 to 101. Sorbitol, metrazol and caffeine were repeated but blood pressure gradually fell and patient died about 12 hours after admission.

DIFFERENTIAL DIAGNOSIS

Dr. Nicholas Preston: This 49 year old male farm laborer claims that he was always strong and well previous to the onset of this present illness. The differential diagnosis must include therefore many of the occupational hazards to which he was ex-

posed, and, since an active farm laborer comes in contact with many domestic animals brucellosis is considered first. This disease would explain vague recurrent aches and pains in the muscles in his arms and legs and ready fatiguability and general malaise for a period of several months. However, patient has not complained of sweating or feeling feverish at any time. Laboratory data revealed no leukopenia which is an occasional finding and, since brucellosis rarely affects the appearance of the patient, this diagnosis can be discarded.

A second possibility is trichinosis. It is very possible that animals have been killed for food and that improperly cooked pork may have been eaten at some time or another. Eosinophilia which is an inconsistent finding in the laboratory data further suggests the possibility of this disease. However, in trichinosis patient has tender muscles in his arms and his legs and they are usually very painful on motion. The eyes are very red as well as swollen and at times the patient feels severely ill. This would account for his not looking right to his colleagues and to the swollen and baggy lids. However, in the physical examination we find that there was no muscular tenderness in either upper or lower extremities. This may not rule out the diagnosis entirely, but makes it unlikely, though it is obvious that biopsy of muscle and perhaps skin tests should have been done which probably would have assured such a diagnosis.

Pernicious anemia must be considered since the patient did complain of prickly sensation in his fingers and occasional numbness in his arms and legs, general malaise, fatigue and the fact that he was slipping may be pertinent findings in the history. However, laboratory data reveals that hemoglobin was 12.3 grams and the red count was 4,160,000 and if this disease is progressing for months as was known in this history these findings would be relatively unlikely. At the same time a gastric malignancy might be considered but this is disregarded because the most frequent complaints are usually pertinent to the G.I. tract, weakness, malaise, anorexia, weight loss and such findings would be the highlights in the history.

Pulmonary tuberculosis or even pulmonary malignancy can be considered, although again the highlights in the history would probably be pertinent to dyspnea, cough, bloody sputum and perhaps pain in the chest. However, these are not the findings in the history and a doctor who had first seen this patient would not be led astray we assume, by the chief complaint of aches and pains in the arms and legs.

Lead poisoning of course would give a different picture. Perhaps the chief complaint in this case, before peripheral nerves are involved, would be severe abdominal colic and again we discount this diagnosis since on the differential blood count nothing was mentioned of abnormal red blood cells. Myasthenia gravis can be considered. However, there is no history of difficulty in keeping the eyes open, dribbling, weak mastication, nasal speech, or regurgitation. Patient does complain of weakness following muscular movement but again there is no difficulty in swallowing, no dyspnea and other signs which usually appear first before the heavier larger muscles of the body are involved. We must keep in mind that the patient not only presented subjective signs but objective signs were also present. He didn't look right to his associates, lower lids were swollen and baggy, skin of the hands was thick, chapped and fissured, bilateral frontal alopecia, hair gray, dry and coarse, puffiness of face and lips. Here we must consider some glandular disorder such as acromegaly or hypothyroidism. We can discount the former since there were no bony enlargements and the course of the disease is only of a few months duration. Usually it takes years to produce different facies, once acromegaly had gotten started. There were no typical large mandible or protruding frontal bones, high cheek bones or spade-like hands, there is no history of change in patient's feet, for example, which the patient frequently discovers by himself. With hypothyroidism we find that the fact that the patient didn't look right and didn't act right is consistent with such a diagnosis. These patients are usually mentally and physically sluggish and could be looked upon as "slipping" by their friends. These patients frequently have arthritic pain and aches in the muscles of arms and legs. They usually have fatiguability and malaise, skin becomes edematous, thick and shinny, the hair coarse, scanty and occasionally patients may comment on their inability to tolerate heat and cold. However, in a case such as this a robust farm laborer who is very active would probably pay little attention to such subjective sensations and he would be more prone to complain of generalized muscular aches and pains, fatiguability. It must be remembered that chronic glomerulonephritis may give some of these historical and physical findings. In a similar way, patient may have swollen baggy lower lids. He may have malaise and

fatiguability and weight loss. However the urine here was negative and the specific gravity appears to be within normal limits. There is also no history of nephritis elicited but chronic glomerulonephritis can not be discarded entirely as a possibility in this case. Periarteritis nodosa must be considered. The patient has had abdominal pains, nausea without vomiting, pains in his arms and legs. All these symptoms can be accounted for by such a lesion. The eosinophilia is also consistent with such a diagnosis. However, again this disease does not have such a subtle onset and I believe it would manifest itself more vigorously. Diabetes mellitus may have given the patient malaise, fatigue, nausea and vomiting and perhaps abdominal pains. However, this diagnosis can be readily discounted since the sugar was negative, and there is no history of polydipsia, polyphagia and polyuria. The few small discrete lymphnodes that were palpable in the neck and axilla cannot be entirely discarded and this brings to mind a lymphomatous disease. However, it is believed that such a disease as Hodgkin's disease would again give symptoms such as cough, pruritis and perhaps the blood picture would be slightly different. Rheumatoid arthritis cannot be discounted entirely since this disease can readily be superimposed on some other and the fact that the patient was relieved by salicylates and seemed much peppier on discharge, proclaims the fact that the patient may have had a rheumatoid arthritis.

The patient's second hospital admission is rather confusing. It is quite obvious that the patient had a pulmonary congestion from the rales which are heard throughout the entire chest and the fact that he remained afebrile helps us rule out a number of possibilities, but the fact that he suddenly became irrational and even unconscious is rather difficult to explain. We know that the toxic dose of codeine is approximately 5-10 grs. and the fact that he had taken 3 grs., if he had taken it, explains very little. However, it is a known fact that patients with hypothyroidism are extremely sensitive to opiates and this dose of 3 grs. may have been more toxic to this specific patient than to a normal individual. Again this does not explain the whole picture. We are also aware of the fact that hypothyroidic patients may have a low blood pressure due to a weak heart, but here we see a blood pressure of 150/90. This can not be explained and is very confusing. The two plus albumin that we find in the laboratory data on the second admission may be explained by diminished renal flow, anoxia of the renal capillary bed and perhaps increased permeability. However, his sudden demise is very confusing and cannot be adequately explained in view of the findings that we have presented to us. It is believed therefore that the findings are consistent with hypothyroidism and myxedema and pulmonary congestion.

DIAGNOSIS

Hypothyroidism.
Myxedema.
Pulmonary congestion.

ANATOMICAL DIAGNOSIS

1. Thyroid atrophy and fibrosis with myxedema
2. Myxedema heart.
3. Pericardial effusion.
4. Cerebral edema—marked.
5. Pulmonary edema and atelectasis—slight.
6. Gastritis.
7. Adenoma of adrenal.
8. Congestion of kidneys.

PATHOLOGICAL DISCUSSION

Dr. Collins: The autopsy findings confirmed Dr. Preston's conclusions. The thyroid was small, hard and light colored. On gross section it cut with marked increased resistance and presented a firm white cut surface, fibrous in nature. Both lateral lobes were small, the right one measuring 3 x 2 x 1 cm., while the left was only half that size. Most of the parenchyma has been replaced by fibrous tissue and a small group of acini remaining. These acini are small and only an occasional one contains colloid. There is little evidence of inflammatory reaction, though one notes a few scattered infiltrating round cells. The heart was much dilated and moderately hypertrophied. It weighed 480 gms. The right heart particularly was dilated and hypertrophied giving the appearance of acute cor pulmonale. The tricuspid valve measured 14 cm; pulmonic 9 cm; aortic 8 cm; mitral 11 cm. Sections of the heart showed rather thick muscle fibers, many of which are fragmented. Individual muscle fibers are separated from each other by rather wide empty spaces which may have contained fluid, possibly this would pass for so called myxedema heart. The lungs showed some pneumonic consolidation, but microscopically there is no evidence of fibrosis to account for the cor pulmonale. The pulmonary arteries were free of emboli. The only other remarkable finding

involved the brain. There was marked edema of the brain so that this organ weighed 1650 grams. The ventricles were small and compressed due to brain swelling. There was a marked pressure cone on the under surface of the cerebellum, no evidence of tumor or hemorrhage. The exact mechanism of death was not clear. Athyreosis and myxedema were quite evident. As Dr. Preston has pointed out patients with myxedema are over sensitive to opiates and it seems possible that the large dose of codeine may actually have been taken with resulting marked cerebral edema. One might hypothecate that the cerebral edema resulted in a compensatory hypertension which proved an over-load for the myxedema heart with acute heart failure. This of course is pure conjecture.

PADDED VERSUS SKIN-TIGHT UNNA'S BOOT AND SIMILAR TYPES OF LEG BANDAGES

EGMONT J. ORBACH, M.D., *New Britain*

THE conventional technic of the skin-tight Unna's boot, as described in many of our leading text books,[1] is not based upon rational physiological principles. It is doubtful whether the zinc oxide of the zinc oxide-gelatin mixture has any therapeutic effect upon the skin after the bandage has become dry. On the contrary, the dry zinc and gelatin mixture is apt to irritate the skin mechanically, and the subsequent dermatitis is not of an allergic nature but is one that is mechanically produced.

The therapeutic purposes of the skin-tight Unna's boot, such as immobilization of the skin and elastic compression of the soft structures, are defeated as soon as the bandage becomes dry. This disadvantage is eliminated by the incorporation of a layer of sheet wadding into the bandage.

Looking at the normal skin as nature's supportive boot encasing the fascial, muscular and vascular structures, we find that the epidermis and corium as supporting layers are not directly attached to the fascia or to the periosteum but are separated from them by the compressible subcutis, acting as a padded layer.

The "kinetic" character of supportive bandages is represented by Unna's cast, requires the incorporation of a protecting compressible layer in contradistinction to the "static" character of the plaster of Paris cast, where padding is very often inadvisible.

The "static" character of the skin-tight plaster of Paris cast has for its purpose the immobilization of the whole extremity including the joints, whereas the purpose of the "kinetic" zinc-gelatin bandage is elastic compression of the soft structures of the extremity, achieved by rhythmic contraction of the muscles under optimal freedom of joint motion.

Using an Unna's boot in cases of a gravitational or postphlebitic syndrome, where the nutrition of the skin itself is damaged by the underlying pathology featured by fibrosis of the arterioles, any further damage to the superficially lying vascular rete subpapillare should be avoided. It is to be remembered that the stratum corneum and stratum lucidum are not pliable and will create pressure damage to the rete subpapillare if it were not for the very thin pliable and padding layer of the stratum granulosum and stratum germinativum. A study of the arterial supply of the corium will demonstrate the necessity of a padded layer in the use of the kinetic Unna's boot-type of bandages. Jaeger[2] as well as Birger[3] emphasize the inclusion of a padding layer in their technic of leg bandages.

M. B. Sulzberger[4] recommends following modified technic for Unna's boot: viz., "The extremity is encased in a stockinette bandage; the warm liquid zinc-gelatin-mixture is applied to the stockinette and is then firmly bandaged over with close, neatly applied windings or ordinary gauze bandage. The ends of the bandage are kept from cutting by inserting cotton wadding between the skin and the gauze. This method is superior to the application of zinc-gelatin directly to the skin, followed by the application of cotton wadding, or the tedious application of zinc-gelatin directly to the bandage."

The use of elastoplast bandages applied direct to the skin should be discouraged as unphysiological.

Any type of pressure bandage should be supplemented by a padding layer. I saw a great many phlebitic ulcers develop after use of a skin-tight elastoplast bandages. In one of my cases it took nearly 4 months to cure one facitial ulcer. These ulcers start with a necrosis of the stratum corneum which becomes adherent to the adhesive coating of the bandage and is torn off with the removal of this bandage. The papillae are denuded, become infected and necrotic, resulting in deepening and enlargement of the defect.

The padded Unna's boot consists of the following layers:

1. Unguentum or pasta zinci to cover the skin of the leg.

2. A single layer of dry wide-mesh 3 inch gauze bandage.

3. A single layer of sheet wadding.

4. A 4 inch wide-mesh gauze bandage saturated with the zinc-gelatin mixture. This layer has to be painted (reinforced) with warm liquidfied zinc-gelatin mixture.

5. A 3 inch wide-mesh gauze bandage. The heel has to be entirely included into the bandage.

SUMMARY

1. It is advisable not to apply the zinc-gelatin directly to the skin but to incorporate a single layer of sheet wadding between the skin and zinc-gelatin boot, for padding.

2. Failure to follow this precept is likely to result in mechanical irritation of the skin or even in phlebitic or necrotic ulcers.

REFERENCES

1. Allen, V. A., Barker, N. W., and Hines, E. A.: Peripheral Vascular Diseases. W. B. Saunders Co., Philadelphia, 1946. P. 745.

2. Birger, Inge: The Chronic (Second) Stage of Thrombosis in the Lower Extremities. Its Course into Crural Ulcer and its Treatment. Acta Chirurgica Scandinavica. Vol. 95, Supplement 129. Lindstedts, Lund, 1947.

3. Jaeger, F.: Cited by Birger, Inge, Aetiologie und Therapie der Varizen. Barth, Leipzig, 1936.

4. Sulzberger, M. B., and Wolf: Dermatologic Therapy. The Year Book Publishers, Inc., Chicago, 1940. P. 144.

BILATERAL CAVERNOUS SINUS THROMBOPHLEBITIS

Complete Recovery in a Case With Multiple Systemic Complications

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CAVERNOUS sinus thrombophlebitis was usually fatal prior to the advent of chemotherapy. There were 58 recoveries reported before the use of sulfonamides.[1] In the majority of these recovery was attributed to surgical drainage of foci of infection. Direct surgery on the cavernous sinus was successful in a small number of cases. In scattered instances cure was ascribed to the use of sera and vaccines, and to transfusions of blood from immune donors. Spontaneous recoveries also were reported. The diagnostic criteria were ill-defined in many of the early case reports.

Since 1936 there have been increasing numbers of reports of recovery through the use of sulfonamides, penicillin, and anticoagulants. Coincidentally, the incidence of the disease has decreased because of the amenability to chemotherapy of conditions predisposing to its development.

Discussion in the literature of the complications of cavernous sinus thrombophlebitis is limited almost

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solely to its intracerebral sequelae. Brethauer[2] has reported a case in which multiple pulmonary abscesses of metastatic distribution occurred 3 months after recovery from cavernous sinus thrombophlebitis. Bacteriologic confirmation of the relationship between the two infections was not obtained.

The case which we report here is noteworthy because of its many systemic complications requiring combined medical and surgical management.

CASE REPORT

J. V. M., a 21 year old radio shop worker, entered the hospital in semi-coma on April 2, 1947. He had had frequent head colds characterized by nasal discharge and headache since 1944, and about 4 weeks prior to admission had noted onset of severe frontal headache. Thereafter, he was persistently weak and listless, and after 1 week he stopped work. He then developed a cough productive of greenish sputum. At that time his family noted that his right eye was unusually prominent. He was seen as an out patient at another hosiptal and was told that his symptoms were due to a cold. He had some chilliness at this time but no known fever. Two weeks before admission he developed stiffness of his neck and pain on opening his mouth. These symptoms were attributed by the patient to swollen glands in the back of his neck. One week before entry he had onset of right chest pain which was diagnosed as pleurisy by a local physician. Three days prior to admission his family noted that his skin was yellow and his urine very dark. Thereafter, he rapidly became acutely ill. The right eye bulged more markedly; the jaundice grew more intense, and on the day of admission he was "delirious." No specific therapy had been given.

On examination the patient appeared moribund. He was semi-comatose, emaciated, deeply jaundiced, hyperpneic, and markedly dehydrated. There was pronounced exophthalmos and complete ophthalmoplegia on the right and some edema of the upper eyelid on the left. The fundi showed dilatation and engorgement of the retinal veins. The neck was stiff, but there were no Kernig and Brudzinski signs. Breathing was rapid and shallow with splinting of the right chest. The lower half of the right hemithorax was dull to percussion, and breath sounds and tactile fremitus were diminished. The liver and spleen were not palpable. The temperature was 105 degrees Fahrenheit rectally, the pulse 160, the respirations 40, and the blood pressure, 98 systolic, 60 diastolic.

Examination of the blood revealed a red cell count of 4,200,000, a hemoglobin of 12.5 grams, and a white cell count of 15,450 with 73 per cent neutrophils. The icterus index was 65, the direct serum bilirubin, 4.6 mgms. per cent, and the total serum bilirubin, 6.5 mgm. per cent. The spinal fluid pressure was 240 mm., and the fluid was yellow in color. There were 10 neutrophils per cu. mm. Culture of the fluid showed no growth. The urine was dark brown and revealed 1 plus albumin and 4 plus bile. The total blood proteins were 5.4 grams per cent with an albumin-globulin ratio of 1. The prothrombin time was 100 per cent of normal, and the alkaline phosphatase was 0.5 Bodansky units. The blood non-protein nitrogen was 76 mgms per cent.

The patient's dehydration and azotemia were corrected with parenteral fluids. He was given 100,000 units of penicillin intramuscularly every 3 hours, and sulfadiazine, 1 gram every 4 hours, following an initial dose of 4 grams. Lumbar punctures were carried out twice daily, and 15,000 units of penicillin in 10 cc. of saline was instilled intrathecally. After the patient was hydrated he was found to have a red cell count of 2,600,000, and transfusions of 500 cc. of whole blood were given daily.

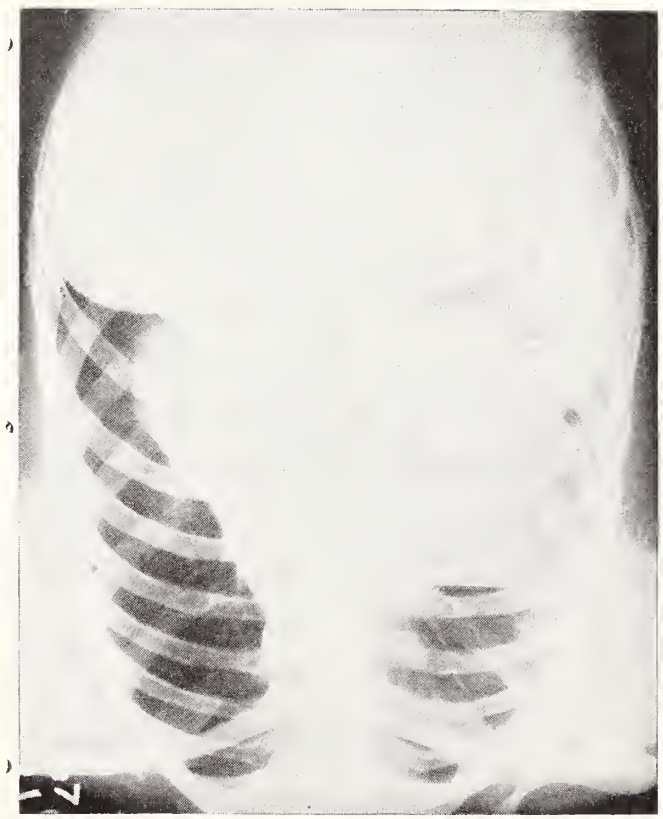


FIGURE 1

Fluid loculated posteriorly in the right pleural cavity extending from the right 6th to 10th ribs with a fluid level at the apex of the pocket. A small amount of fluid is present at the base of the right lung. Residual infiltration at the levels of the 3rd and 4th anterior intercostal spaces on the left

On the 2nd hospital day x-ray of the chest revealed diffuse, linear, and mottled infiltrations involving all the lobes of both lungs, somewhat more marked on the right than on the left. X-ray of the paranasal sinuses showed a mild degreee of clouding of the ethmoids and a more marked haziness of the left maxillary sinus. There was no evidence of osteomyelitis in the skull and sinus films.

On the 2nd hospital day the patient became incontinent, and moderate exophahalmos and partial ophthalmoplegia were noted on the left. At that time a small window was made into the anterior base of the right sphenoid, and pus immediately drained through the opening. On the 3rd hospital day a needle was passed along the medial wall of the

right orbit between the periosteum and the bony wall, and a small amount of pus was aspirated at a depth of 5 cm. An external type operation was then done; the ethmoid cells were broken up, and the anterior wall of the sphenoid was removed. Pus was found in both locations. A small opening 3 mm. in diameter was made into the right frontal sinus through the floor. The mucosa of the frontal sinus was thickened markedly, but no pus was seen. A rubber drain was placed down to the right sphenoid sinus and left in place for 2 days.* Frequent irrigations with a saline solution of penicillin, 11,000 units per cc., were carried out during this period. After surgery the patient was given 300 mgms. of heparin daily for 10 days.

On the 4th hospital day the blood culture taken on admission showed an anaerobic alpha hemolytic streptococcus, and penicillin was increased to 200,000 units every 3 hours intramuscularly. Subsequent blood cultures were sterile. The same organism was cultured from the material aspirated from the right orbit. At no time did it grow in sufficient numbers to enable the performance of sensitivity tests.

On the day following operation the patient showed marked reduction in temperature and pulse rate, but the bilateral periorbital edema and exophthalmos continued to increase during the next 2 days. During this time bilateral retro-aural edema appeared. Thereafter, these signs regressed steadily. The patient developed no new neurological signs, but the spinal fluid revealed a gradual increase in cells to a height of 900, predominantly neutrophils. Intrathecal penicillin was discontinued, and within a week the spinal fluid cell count had returned to normal. By the 8th hospital day the patient was again continent. The red cell count was 3,800,000, and the serum bilirubin and blood proteins were within normal limits. The cephalin flocculation test rose to a height of 4 plus on the 12th hospital day, and became negative on the 27th hospital day.

During the 2nd week of hospitalization the patient's temperature was lower, averaging 101 degrees Fahrenheit rectally. The white cell count continued to rise, however; the patient became dyspneic, and the physical signs were those of increasing fluid in the right chest. On the 9th and 10th hospital days 675 cc. and 365 cc., respectively, of bloody fluid were removed. Culture of the fluid was negative. Thereafter the patient had no respiratory distress. He was completely clear mentally, and the extraocular movements had returned to normal. On the 14th hospital day sulfadiazine was discontinued. Low grade fever and leukocytosis persisted. Repeat thoracentesis yielded no fluid. Penicillin was discontinued on the 21st hospital day. Thereafter the temperature chart showed occasional elevations to 100 degrees Fahrenheit, and a tachycardia of 100 to 120 persisted. There were no significant cardiac findings, and repeated blood cultures during this period were negative.

On the 38th hospital day the patient's temperature rose to 101 degrees Fahrenheit, and x-ray of the chest showed fluid loculated posteriorly in the right pleural cavity (Figure 1). On the following day 30 cc. of thick, green, foul smelling pus was aspirated, and 50,000 units of penicillin in saline was instilled. Culture of this material yielded an anaerobic alpha hemolytic streptococcus identical with the organism previously isolated from the blood and sinuses. Penicillin therapy, 100,000 units intramuscularly every 3 hours, was reinstituted at this time. The temperature remained elevated. On the 41st hospital day thoracentesis yielded 100 cc. of thinner exudate which was sterile. The pleural cavity was irrigated with saline, and 100,000 units of penicillin in saline was injected. The temperature and pulse rate returned to normal immediately. A third thoracentesis, on the 43rd hospital day, produced 40 cc. of thin, sterile fluid. The

*The surgical drainage of the deep sinuses was performed by Dr. Wesley F. Bosworth, resident in otolaryngology and Dr. Aram Glorig, consultant in otolaryngology, Veterans Administration Hospital, Newington, Connecticut.

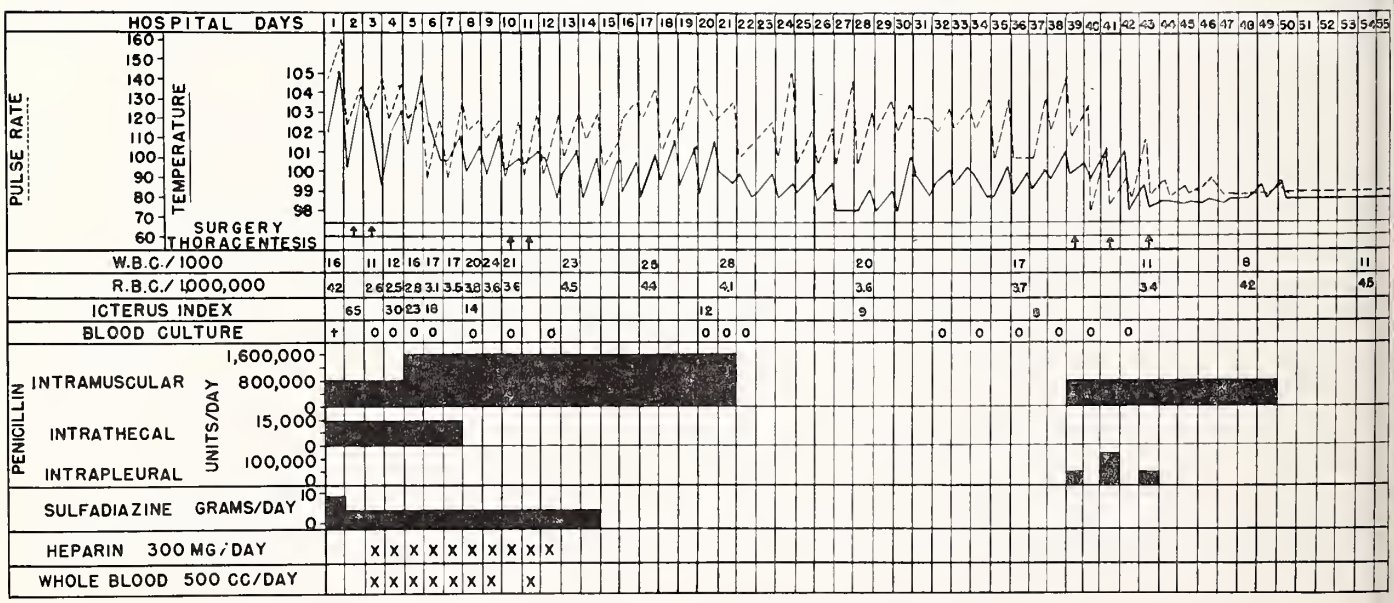


FIGURE 2
Clinical Course

mpyema cavity was again thoroughly washed with 20 cc. mounts of saline and 50,000 units of penicillin introduced. ubsequent x-rays of the chest showed pleural thickening nly. Intramuscular penicillin was finally discontinued on ie 49th hospital day. The patient gained weight steadily) 130 lbs., as contrasted with an admission weight of 96)s. At the time of discharge on the 77th hospital day there ere no residual eye abnormalities; the chest expansion and ital capacity were within normal limits; the operative scar as inconspicuous.

The course, therapy, and some of the pertinent findings re presented in Figure 2.

OMMENT

In retrospect, the patient's illness was initiated by urulent sinusitis. Ultimately, the infection extended o the cavernous sinuses. The resultant septicemia roduced diffuse pneumonitis and subsequent empyema. The severe jaundice was on the basis both of emolysis, as reflected by the anemia, and of liver lamage, as evidenced by the low blood proteins, ositive cephalin flocculation, and biliuria. The liagnosis of cavernous sinus thrombophlebitis was stablished by the presence of progressive exophhalmos with engorgement of the retinal veins, etro-aural edema, and septicemia. It is not thought hat the patient had bacterial meningitis. The increasing spinal fluid cell count during the period f administration of penicillin intrathecally is ttributable to the irritative effects of the drug.

The recovery of this patient, who was moribund because of fulminant septicemia, further illustrates the efficacy of chemotherapy, antibiotics, and anticoagulants in the treatment of cavernous sinus thrombophlebitis. In this case, however, it was apparent that surgical drainage of the sinuses produced the first definite signs of improvement. It should be emphasized that in some cases where the disease stems from an apparent focus of infection, judicious surgical intervention should supplement medical treatment.

SUMMARY

An unusual case of bilateral cavernous sinus thrombophlebitis secondary to purulent sinusitis and complicated by bacteremia, diffuse pneumonitis, empyema, and jaundice, both hemolytic and hepatic in origin, is presented. The offending organism was an anaerobic alpha hemolytic streptococcus. Recovery is attributed to radical drainage of the deep sinuses combined with intensive use of sulfadiazine, penicillin, and heparin.

REFERENCES

1. McNeal, W. J., Frisbee, F. C., and Blevins, A. Thrombophlebitis of the Cavernous Sinus: A Review of Reported Recoveries with Special Reference to Thrombophlebitis of Staphylococcic Origin. Arch. Ophth. 29:231-257, 1943.

2. Brethauer, E. A. Jr. Thrombophlebitis of the Cavernous Sinus: Report of Complete Recovery in Case with Multiple Pulmonary Abscesses Complicating Pregnancy. J.A.M.A. 134:1090-1092, 1947.

WORLD MEDICAL ASSOCIATION SECOND ANNUAL ASSEMBLY GENEVA, SWITZERLAND

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The Second Annual Assembly of the World Medical Association was held in Geneva, September 8, 9, 10, and 11, 1948. Delegates were present from Australia, Austria, Belgium, Bulgaria, Canada, China, Cuba, Denmark, Eire, France, Great Britain, Ireland, India, Italy, Luxembourg, Netherlands, Norway, Pakistan, Palestine (Jewish), Peru, Philippines, Spain, Sweden, Switzerland, Turkey, United States. Observers were also present from the World Health Organization, the American Medical Women's Association, and the International Association of Women in Medicine. The delegates from the United States were Roscoe L. Sensenich, South Bend, Indiana, president of the American Medical Association; Elmer L. Henderson, Louisville, Kentucky, chairman of the Board of Trustees of the American Medical Association; and alternate delegates, John W. Cline, San Francisco; Creighton Barker, New Haven. Morris Fishbein, editor of the *Journal of the American Medical Association*, attended also as an observer.

The meetings of the Assembly were held in the House of Cantonal Representatives in the ancient Town Hall in Geneva. This building is unique in that it has no stairways to its four floors, but inclined paved ramps up which the good and well-fed

statesmen of the Canton of Geneva rode on donkeys to get to the halls of legislature.

Professor Doctor Eugene Marquis of Rennes, France, presided at the meetings and the Secretariat was headed by Louis Bauer, Hempstead, New York, who is the Secretary-General of the Association. Dr. Bauer is also a trustee of the American Medical Association. The sessions were carried on in the three official languages of the Assembly, English, French and Spanish. This was not as complicated as it sounds. All remarks and discussion originating in any language were translated into the other two languages. The official interpreter was Dr. Leon Gerin-Lajoie of Montreal, Canada, formerly president of the Canadian Medical Association and professor of gynecology at the University of Montreal. He was assisted by two young Swiss women; one of them moved around from French to English to Spanish with the utmost ease and at one point, when a question arose, she went over into Italian to clarify it. Because of the frequency of international conferences in Geneva—perhaps there are more there than any other city—these polylingual people are common.

The Federation des Medecins Suisse acted as official hosts for the Assembly and the elaborate local arrangements and entertainment were made by the Medical Association of the Canton of Geneva.

The purposes of the World Medical Association are: (1) To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available. (2) To maintain the honor and protect the interests of the medical profession. (3) To study and report on the professional problems which confront the medical profession in the different countries. (4) To organize an exchange of information on matters of interest to the medical profession. (5) To establish relations with, and to present the view of the medical profession to, the World Health Organization, UNESCO, and other appropriate bodies. (6) To assist all peoples of the world to attain the highest possible level of health. (7) To promote world peace and human freedom.

The agenda for the meetings included many matters of international medical interest and it was pleasing to see how little variation there was in the thinking and sentiment of the representatives from the many countries. The first major item to be considered was the approval of an international pledge in medicine that might be called a brief and modern Hippocratic Oath. However, this had to be called a pledge because there are countries where the meaning of the word oath is at variance with that usually accepted. There was debate over some of the points in this pledge, but finally it was accepted. It is to be called a Declaration of Geneva and says:

"At the time of being admitted as Member of the Medical Profession:

"I solemnly pledge myself to consecrate my life to the service of humanity;

"I will give to my teachers the respect and gratitude which is their due;

"I will practice my profession with conscience and dignity;

"The health of my patient will be my first consideration;

"I will respect the secrets which are confided in me;

"I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;

"My colleagues will be my brothers;

"I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

"I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use any medical knowledge contrary to the laws of humanity.

"I make these promises solemnly, freely and upon my honor."

Reports were presented on worldwide studies concerning, "The Status of the Medical Profession in Twenty-Three Countries," "The Advertisement of Patent Medicines," "Proposals Relative to Universal Medical Qualifications" (the impracticability of this was unanimously agreed to), "Unqualified Medical Practice," "Postgraduate Medical Education," "The Training of Specialists," "An International Code of Medical Ethics," and "Social Security and the Operation of National Health Insurance."

It was this last subject, National Health Insurance, which came in for the longest and the most detailed discussion and debate. There could be no question in any one's mind who heard what these people from all over the world had to say, that the lot of physicians in national health insurance countries was far from happy and, in spite of the impres-

sive fact that each of them was trying to render the best possible service to his people, they knew in their hearts that in the system under which they worked the quality of medical care had deteriorated. Finally a twelve point statement was written and adopted. It sets forth what the medical profession of the world thinks should be the rights of physicians in their relation to politically manipulated systems of medical care, and says that whenever medical care is provided as part of Social Security the following principles should govern:

1. Freedom of choice of physician by the patient. Liberty of physician to choose patient except in cases of urgency or humanitarianism.

2. No intervention of third party between physician and patient.

3. Where medical service is to be submitted to control, this control should be exercised by physicians.

4. Freedom of choice of hospital by patient.

5. Freedom of the physician to choose the location and type of his practice.

6. No restriction of medication or mode of treatment by physician except in case of abuse.

7. Appropriate representation of medical profession in every official body dealing with medical care.

8. It is not in the public interest that physicians should be full time salaried servants of the government or Social Security bodies.

9. Remuneration of medical services ought not to depend directly on the financial condition of the insurance organization.

10. Any Social Security or insurance plan must be open to the participation of any licensed physician, and no physician should be compelled to participate if he does not wish to do so.

11. Compulsory health insurance plans should cover only those persons who are unable to make their own arrangements for medical care.

12. There shall be no exploitation of the physician, the physician's services or the public by any person or organization.

Representatives of a few countries were hopeless in their feeling that some of the points could ever prevail in their countries because already political domination and control of medicine had gone so far that the way could not be retraced.

There was no official consideration of the National Health Act of Great Britain that went into effect on July 5, this year, but there were many opportunities to discuss it with the British representatives. Mostly, they said, that the time of operation had been too short to make any valid observation, yet one could not help but note a tone of wan skepticism in all they had to say. Financially, the British physician may be as well, perhaps better off than he was before, but the amount of work which he has to do, the number of patients he has to see, since he has no choice whether he sees them or not, is staggering. The faults of mass social medicine which have been emphasized so vigorously by thoughtful and well informed persons in America become obvious in discussions with colleagues who work under such systems.

Provision was made for the establishment of a quarterly journal of international medicine. It will be published largely in English and its contents abstracted in French and Spanish, but original contributions will be published in the language of the country of their source. Morris Fishbein is to be the editor of this quarterly.

The World Health Organization, a section of the United Nations, has established formal liaison with the World Medical Association, the first of such relationships to be entered into. Dr. J. Maystre, Geneva, has been designated the liaison official. Dr. Charles Hill, secretary of the British Medical Association, was elected president-elect of the World Medical Association. The 1949 Annual Session will be held in London, the interim meeting of the Council in Madrid, and the 1950 General Assembly in the United States.

The World Medical Association has no illusions with respect to its ability to solve all the problems of mankind, but the organization does hold great promise and recognizes the opportunity that it has to assist all peoples of the world, irrespective of race, color or creed, to attain the highest level of health. In so doing there must be another result, to cement together more closely the elements of friendship and understanding for physicians everywhere.

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EDITORIALS

Medical Public Relations

The field of medical public relations is often misunderstood. It is not the fostering of propaganda in the usual sense of that word. Rather it is a function that evaluates public attitudes and influences policies which are of material interest to the public and the profession in order that we may earn public understanding and cooperation toward a common goal, an ideal in which every one has maximum health. At the present time, when legislation may be imminent which could have a profound and injurious influence on such a development, the importance of enlightening the public of the dangers of ill-advised action cannot be over emphasized.

Certain world wide trends toward what is commonly known as socialization will not be influenced by organized medicine, but medical economic trends in our own country are unquestionably a problem in which we have a major responsibility. At the moment, through the voluntary prepayment health movement, we can make our most important contribution, but along with this development, definite attention must be paid to the distribution of doctors and the quality of medical service. With the proper development of such a program we may hope that federal legislation will be concerned chiefly with assisting medical scientific progress and providing medical facilities for the indigent.

Public relations experts have often said that the best public relations officer is the physician himself. What is meant by this statement is that the physician can be of momentous influence provided he i well informed and has a deep interest in these de velopments. In addition, however, there must b thinking and activity of Medicine as a group at na tional, state and county levels through medica societies. At the national and state levels we hav every reason to feel that great progress is being made At the county level in our own State interest an action is being developed also, although slowly an of quite recent growth. In the comparatively shor time that our State Office has been making a contin ued effort in public relations work, extraordinary progress has been made, especially in recent years To continue this fine work expansion must be con templated. Our leaders, therefore, should have complete support and appreciation of their fin efforts. The function of modern medical public re lations is seen in the following, "Medical leadership must find what is wanted, obviously and sincerely try to gratify its wants, convince people that they like what they are getting."

"The Nation's Health"

A basic need in a democracy is the assumption o individual responsibility. This often is difficult be cause the data upon which decisions are based fre quently is presented in the form of propaganda. The only way to come to a sound conclusion in a debate is to have not only trained proponents but also a trained audience. Not everyone is possessed of the discernment displayed by a canny Vermonter who

as asked by his neighbor what a speaker was talkg about. After pausing for reflection the reply as: "He don't say."

Since the report to the President by the Federal curity Administrator was published on September of this year, there have been widespread coments by organizations and by individuals with ested or other interests in both sides of the probms raised. To some "it puts the question of comulsory health insurance into the political arena," hile others hale it as a solution for the health needs f the nation and "call upon Republicans and Demorats alike to enact this program into law." In some inds the report gives no evidence that the conmplated expenditure of $10 billion a year would ield the benefits promised, and the report itself is garded as a questionable document. A report on ealth issued by the Federal Security Administrator instead of the U. S. Public Health Service aturally arouses questions, if not even suspicions.

Practicing physicians naturally will be interested the proposals for a system of government prepayment health insurance. These proposals constitute the backbone of the report and occupy 52 of he 186 page document. It is greatly to be hoped hat all physicians will study the entire report and nake up their own minds without reference to the barrage of propaganda which even now is assailing hem.

The important questions to be decided are: (a) whether prepayment government medicine would provide the promised benefits; (b) whether, if they would, the effect would be to strengthen or weaken he public's sense of individual responsibility. There are good reasons for believing that serious inroads have already been made into this essential function of a democracy. To some minds, at least, it seems fully as important to safeguard the moral integrity of the nation as to chase the pot of gold at the end of the rainbow. This might easily turn out to be dross.

Physicians particularly will need to give real thought to that part of the report which declares hat families with incomes below $5,000 a year are unable, without aid, to meet the costs of serious illness. Nearly 80 per cent of our families fall into his group and it is difficult to reconcile this declaration with the fact that some of these families now spend astonishingly large sums on nostrums, charlatans, medical gadgets, cosmetics and liquor. Is it reasonable to set up a vast health program to compensate for a condition which may be largely due to improvidence?

Both physicians and the public will want strong assurances that such a plan would yield the desired results in the form of more and better health care. No such assurance is obtained from the experience gained in the most important areas of public medicine so far undertaken in this country. Actually the opinion is widely held that public medicine has been of a pretty unsatisfactory order. Physicians are therefore bound to be doubtful and the public probably will join in this when the facts are at hand.

Physicians and the public share alike in their desire for the extension and improvement of all health services. One of medicine's most prized traditions is the lack of commercial motivation. This attitude will continue to be a force in medical progress. The public must be able to see by our behavior that our hesitation in accepting the idea of government medicine is not based on selfishness. That, in fact, the object of physicians, now as always, is to provide health services of all kinds on the highest possible plane and in the most effective and constructive manner.

Training for General Practice

Most recent statistics from the Council on Medical Education and Hospitals of the American Medical Association show that the number of residents now in special training approximates 10,000. About one-third of these will finish training this year, with the medical schools graduating 5,600 students. Thus it is plain that the ratio between these two groups is disproportionate. In reviewing the situation *New York Medicine* recently commented, "If we are to continue to base our medical education program on the single objective of producing good doctors in sufficient numbers to safeguard the health of the nation, we must show young physicians that the specialist is a by-product of the general practitioner." A pertinent question may be raised concerning training for the recent graduate who wishes to practice general medicine. It is obvious that the old-style one year rotating internship is not adequate. At the present time there is little alternative for the young physician who has finished such an internship but to enter a medical or surgical specialty. It should not be too difficult, however, to determine the type of second and third year training program which would serve the purpose of adequate training for general practice. It would be helpful, however, to

know what constitutes general practice in our State as contrasted with that of 25 years ago. The newly formed general practitioners group could be very helpful in such a survey and, with knowledge available, the feasibility of developing certain residency programs for general practice could be developed along with specialty programs in our hospitals.

If centrally controlled federalized medicine is ever demanded by our citizenry, it could be because they have come to feel that the services of those engaged in general medical practice are either not available or are inadequate for their needs. That this should not occur is the responsibility of the entire medical profession. That it may not occur means that every support should be given to this basic and indispensable type of medical practice, and that opportunities for adequate training must be available to the young graduate.

Night Calls

Many are called but few get up.
Anon.

I would hesitate to discuss the matter of night calls by physicians had it not already been pretty thoroughly ventilated in the public press, mainly as the result of some unfavorable, and in part exaggerated, newspaper criticism which originated in the Far West. Investigation shows, however, that the situation is not confined to any one section of the country, but that for some reason or reasons the practitioners of today refuse to respond to night calls from patients to an extent that did not prevail a couple of generations ago. Inasmuch as situations of this sort irritate the public, and any medical matter that annoys them is likely to increase their tendency to adopt socialized medicine, the question is not without significance. Not that socialized medicine would help as the public may think, for recent British experience, as recorded in the *Reader's Digest* for August, shows what a mass of medical red tape can entangle the practitioner, at least under the British system. Nor is there much doubt that with the American love for organization and paper work the situation here, under socialized medicine, would also be accompanied by such handicaps to professional efficiency and morale.

It is doubtless true that the people themselves are in part responsible for the reluctance of medical practitioners to leave their comfortable beds a issue forth into the night, often in inclement not say extremely disagreeable weather. Quite often t family of the patient puts off calling the doct much longer than they should, and frequently t physician finds when he reaches the patient th some panicky individual has hauled him out for son trivial ailment. But, no matter how true this may b there are still real emergency cases which must ha prompt attention. What would we think of an ol stetrician, for example, who refused to go out night? What should we think of a practitioner wh gets a call from a patient whose story suggests acu appendicitis, coronary closure or acute edema of t lungs, and who declines to respond to it? The answ can hardly be categorical, for it depends to som extent on the circumstances.

There is no question that the life of a pyhsicia may be shortened by his experiences, indeed Osl once spoke of a practitioner and friend who die prematurely of cardiovascular disease, as a "victi of the life of a general practitioner." Indeed, n only popular family doctors but also surgeons, an above all obstetricians, are likely to suffer from ove work and lack of sufficient rest and, if they are n of pretty tough fibre, they are snuffed out early However, entering medicine is like getting marrie one should embrace his profession for better or fo worse. In any profession it is assumed that the aspir ant has entered into the study of his chosen caree with a knowledge of both its advantages and it drawbacks, and a tacit acceptance of the same There is, of course, no career without both advan tages and drawbacks. One wonders to what exten the present revolt against night work is due to th fact that fifty per cent of the profession is now mad up of specialists, and how much is due to a desir on the part of physicians to escape the well know rigors of their calling? Indeed, it is difficult to se how even specialists can legitimately decline som night work, for there are indubitably eye emergen cies, throat emergencies, lung emergencies, hear emergencies, etc. It would be distressing to assum that what one might call the "index of humanitarian ism" was declining in the medical profession, fo that would indicate a deplorable commercializatio of an honorable and merciful profession.

G. B.

Connecticut and Hospital Births

According to information recently released a new gh record was set in 1946 for the proportion of ths delivered in hospitals or institutions. Of the 88,672 live births recorded for that year 2,708,223, 82.4 per cent, occurred in hospitals; 402,759, or .2 per cent, were attended by physicians outside hospitals; and 177,690, or 5.4 per cent, were attended by midwives or other non physicians. This ange in obstetrical practice is a comparatively cent one, for in 1935 only 36.9 per cent of the nfinements occurred in hospitals, about half (50.6 r cent) of the registered births were attended tside hospitals by physicians, and 12.5 per cent ere attended by midwives and others.

Relatively large differences existed in 1946 in the oportions of births attended by physicians (in or t of hospitals) and of births occurring in hospitals between the white and non white groups and tween the residents of urban and rural areas. hile almost all (98.4 per cent) of the white births ere attended by physicians and about seven in ght (87.1 per cent) occurred in hospitals, for non hite births less than two out of three (65.2 per nt) were attended by a physician and less than lf (45.2 per cent) occurred in hospitals. The differences were less marked as between residents of ban and rural areas. For urban residents, 97.9 per nt of the registered live births in 1946 were attended by physicians and 92.5 per cent occurred hospitals; for rural residents, the corresponding oportions were 89.6 per cent and 67.1 per cent.

Connecticut heads the list of states in the percentge of hospital births with 98.9 per cent, Washingon is second with 98.2, Oregon third with 98.0. Our mmediate neighbors are high also on the list: Massausetts 97.2, New York 96.9, Rhode Island 95.2.

These are impressive figures and certainly show at hospitalization and its attendant benefits, is a reat, probably the greatest single factor in the lowring of the maternal death rate. It is more than a oincidence that our own state also heads the list this field. While such figures bespeak an improvent in the quality of maternal care they come also a challenge to physicians and hospitals alike to an d that such care must be constantly guarded and nproved if we are to continue to satisfy a public emand which appears to be so justified.

The New Auxiliary Bulletin

Hats off to the ladies! Our State Woman's Auxiliary has gone well out in front to issue its own publication, a quarterly *Bulletin*. Bound in a bright autumnal color, printed by the offset method, the first issue contains a "President's Message" from Mrs. Charles W. Goff, "Music for Mental Ills" by Mrs. Arthur A. Tower, "Rural Medical Service" by Dr. Norman H. Gardner, "Washington Highlights" by Mrs. Robert J. Cook, and several book reviews by Mrs. Edward R. Smith, the editor.

The two center pages carry a list of county editors and chit-chat from six counties. Inside the front and back covers may be found a list of the officers and committee chairmen, the advisory council, the editorial board, and the names of the County Auxiliary officers—all a bit difficult to read because of the colored background. The only printing on the front cover is the State Medical Society seal.

Our hearty congratulations to the chairman of the editorial board, Mrs. Paul S. Phelps, to the editor of the *Bulletin*, Mrs. Edward R. Smith, and to the other members of the board. We welcome our new child.

From Our Exchanges

Farber et al report 5 cases in *The New England Journal of Medicine* (June 3, 1948) of acute leukemia in children in which remissions were obtained by the use of folic acid antagonist, aminopterin. This is not a cure but offers a promising field for further research.

A new conception of angina pectoris has been advanced by Wyburn-Mason in the *British Medical Journal* (May 22, 1948). This author presents evidence to show that anginal pain may be caused by disease of both the tissues of the mediastinum and the heart. Excessive activity in the vasodilator pain fibres in the posterior nerves roots passing to the mediastinal structures and the coronary vessels, not necessarily anoxia, is given as the predisposing cause of the angina.

Irving Shapiro, M.D., writing in *The Journal of the Medical Society of New Jersey*, reports a nail polish base coat as a new cause for the shedding of nails. All the cases could be traced to a single popular proprietary base coat and cleared up on removal of the cause.

PROGRESS IN CLINICAL MEDICINE

DRUG TREATMENT OF EPILEPSY

MARGARET A. LENNOX, M.D., *New Haven*

THE pharmacologic treatment of epilepsy has advanced so rapidly in the past few years and there is so much continued advance at present that it seems likely that our present teaching of epilepsy will be outdated in a few years time. It would seem profitable, therefore, to summarize our present experience with drugs in the treatment of epilepsy. No attempt will be made, in the present article, to review the literature completely, but only to summarize the results obtained with some of the newer drugs in the Seizure Section of the Psychiatric Out-Patient Clinic of the Grace-New Haven Community Hospital.

Until ten years ago, phenobarbital and bromides constituted the therapeutic armamentarium in the treatment of epilepsy. The first clinical reports on the use of dilantin in 1938,[1] of tridione in 1945,[2] and of mesantoin in 1945,[3] opened the now highly competitive field of new and more effective anti-convulsants. At present, in addition to the by now traditional mainstays, dilantin and phenobarbital, tridione and mesantoin are available on prescription. Paradione has had preliminary clinical trial,[4] and phenurone, after receiving extensive and critical clinical trial by Gibbs,[5] is now being made available to other clinical investigators. A few other drugs, as yet unreported, are undoubtedly being tested in partial secrecy, testifying to the competitiveness of the field.

By way of orientation, a brief capitulation follows of the various types of seizures which constitute the syndrome of epilepsy.

1. Grand mal convulsions: the familiar tonic-clonic convulsion which is similar in all respects, when it occurs spontaneously, to the major convulsion produced by electro-shock.

2. The petit mal triad, classified together on the basis of EEG findings and response to therapy.[2]

(a) Petit mal spells: brief episodes, lasting usually no more than a minute, of loss of consciousne associated with rhythmic clonic jerks of the muscl of the head or face, rarely of the extremities, an almost never accompanied by falling. These spel occur almost exclusively in children, tend to occu frequently in affected patients, usually no fewe than ten spells a day, can be precipitated by hype ventilation and can almost invariably be diagnose by the EEG.

(b) Myoclonic jerks: jerks of isolated flexo muscle groups, usually of the extremities, involvin different muscle groups in the same patient a different times, not associated with loss of conscious ness.

(c) Akinetic attacks: abrupt loss of postura control resulting in a precipitous fall. The patien can get up immediately and may not lose con sciousness.

3. Psychomotor seizures: bizarre and variable i their manifestations from patient to patient and i the same patient but usually characterized by abnor mal or inappropriate behavior and amnesia for th event. When brief, the spells are often mistaken fo petit mal but can be differentiated on the basis of th EEG findings, age of the patient, and prodromat and sequelae. Patients with petit mal spells do no have an aura, and the return to consciousness i abrupt and complete; patients with psychomoto spells frequently have an aura and the return to consciousness is often slow, characterized by con fusion sometimes so profound that the patient is completely unaware that a spell has occurred.

4. Focal seizures:[6] almost always secondary to focal intracranial pathology with symptoms dependent on the area of the brain involved. Any type of pathology may produce focal seizures: tumor, vascular accident, head injury, meningitis, encephalitis, abscess, birth injury, etc. Any type of focal seizure may remain localized, in which case it is usually

From the Department of Psychiatry, Yale University School of Medicine

t associated with loss of consciousness, or it may ogress to a grand mal convulsion, in which case nsciousness is lost. Seizures associated with lesions the frontal lobe usually consist of turning of head d eyes to the opposite side; in the motor area, of ntralateral clonic jerks; in the sensory area, of ntralateral paresthesias; in the occipital lobe, of formed visual hallucinations (lights, stars, etc.). sions in the temporal lobe may give rise to a wide riety of seizure symptoms: formed visual hallunations, episodic aphasia, hallucinations of smell, nce-like states, feelings of unreality, deja vue enomena, auditory hallucinations, episodes of zziness and tinnitus.[6]

From the point of view of drug therapy, focal and and mal seizures act alike, petit mal spells tend to spond oppositely, and psychomotor seizures act e neither, but resemble grand mal more than petit al spells. Unfortunately, many patients have sevral types of spells, and the therapeutic problem is uch more difficult in these cases, since the specific edicine for each type of spell must be given.

For the past ten years, dilantin has been the most tisfactory drug for the treatment of grand mal and, sychomotor seizures, and there has been no effecve treatment for petit mal spells. With the advent tridione, this picture has been changed.

SULTS WITH TRIDIONE

Our experience with tridione has been somewhat ss favorable than that reported.[2] Of fifteen patients ith petit mal, four have been seizure free or ninety er cent improved, four have been fifty per cent nproved, and seven have been unimproved. Myoonic jerks have responded as well as petit mal ells. Like others,[2] we have noticed an exacerbation f co-existent grand mal convulsions, some patients aving their first grand mal attack in years after eatment with tridione was instituted. Contrary deJong's experience,[7] our patients with psychootor seizures have not improved on tridione. Minor xic symptoms, chiefly photophobia, have occurred twenty-five per cent of our patients.

The report of fatalities due to aplastic anemia and f fifteen per cent neutropenia in patients on idione[8] renders it imperative that monthly comlete blood counts be obtained and the drug be ithdrawn if the *total neutrophils* fall below 2000. ortunately, no case of neutropenia due to tridione as been seen by us.

RESULTS WITH PARADIONE

Paradione is eminently effective in the treatment of petit mal spells. Of fourteen patients, only one has failed to experience improvement, five are fifty per cent improved and eight patients are seizure-free or have ninety per cent improvement. Other manifestations of the petit mal triad are less regularly and less startlingly improved. Paradione exacerbated psychomotor seizures in one case, but did not appear to exacerbate grand mal seizures, when these coexisted with petit mal attacks. The average dose is three capsules a day, and four is the highest dose that has been required. Minor toxic symptoms are rare, and required withdrawal in only one case: a patient who had rather severe sunglare. Two patients had mild sunglare, one drowsiness and one a mild acne-form rash.

Neutropenia requiring withdrawal of the drug occurred in fifteen per cent of the patients treated. It occurred in the third or fourth month of treatment in all cases. The lowest count observed was a five per cent neutrophil count with a total count of 5,000, i.e. a neutrophil count of 250. In two cases, including this one, medication was resumed cautiously when the white count had returned to normal and no further drop occurred.

With paradione, monthly complete blood counts are more important than with tridione.

In our experience, paradione is preferable to tridione for the treatment of petit mal epilepsy. It is more effective; it does not accentuate grand mal seizures; it can be given in conjunction with dilantin and phenobarbital; there are fewer minor toxic reactions (rash, sunglare).

In our experience, paradione has these disadvantages as compared with tridione: it is not beneficial in patients with myoclonic jerks; the incidence of neutropenia is greater than with tridione; it cannot be withdrawn without some risk of greatly exacerbating the number of spells, and in some cases, the spells do not respond as favorably on the second trial as on the first trial.

CASE REPORT

N. K., an eight-year old school girl, developed petit mal spells at the age of six. These did not respond to tridione, and she was having a petit mal spell at least every five minutes. During these, she would lose consciousness, have clonic jerks of the head and face, and slump to the floor. EEG indicated petit mal epilepsy. After four weeks on paradione 0.3 gm t.i.d., she became seizure free and has remained so for a year on the same medication.

RESULTS WITH MESANTOIN

Our results with mesantoin, too, have been less encouraging than those reported by other observers.[3,9] One in five of our patients tried on mesantoin has had startling improvement: no seizures on mesantoin as compared to no improvement on dilantin. Almost all such startling improvements have occurred in patients with psychomotor seizures. Although the number benefitted is small, the degree of benefit in these individuals has justified the use of mesantoin when dilantin fails. Mesantoin must be started at 0.1 gm a day and increased by 0.1 gm a day at monthly intervals until seizures cease or drowsiness prevents further increase (0.6 gm daily is the maximum dose we have given). *Only then is it safe cautiously to decrease other anticonvulsant drugs the patient may have been taking.* Failure to observe these precautions has resulted in near-fatal status epilepticus.

Mesantoin has caused such severe drowsiness in a quarter of our patients that it has had to be discontinued. Rash has been seen once.

CASE REPORTS

M. H., a thirty-eight year old married woman, had had psychomotor seizures since the age of twenty. These occurred three times a week, and during them she would behave peculiarly for twenty minutes and afterwards have no memory of what she had done. EEG was normal. Dilantin was not beneficial. On mesantoin 0.1 gm q.i.d., she has had no spells for a year.

H. H., an eighteen year old boy, has had focal (visual) and grand mal convulsions since encephalitis at the age of twelve. EEG shows a right occipital focus. Pneumoencephalogram shows a right occipital porencephaly. He was well controlled on dilantin 0.1 gm six-a-day, having had no seizures in a year. Nevertheless, his physician prescribed mesantoin 0.1 gm q.i.d. and discontinued dilantin at the same time. Within two days, the patient developed continuous convulsions which required a week of hospitalization for even partial control. After discharge, he was again placed on dilantin six-a-day and has had no seizures for six months.

RESULTS WITH PHENURONE

The enthusiatic report on phenurone[5] mentions only one drawback. Gibbs reports that psychotic episodes may occur as a toxic manifestation. This was true in the one case treated by us to date. Although this patient's psychomotor seizures were markedly improved, severe depression requir withdrawal of the drug.

Several other drugs are under trial and are givi encouraging results.

SUMMARY

Drug therapy in epilepsy, like drug therapy infectious diseases and blood diseases, has change so rapidly in the past few years that it is difficult f any but the specialist to keep abreast of therapeut developments. The present status of drug therap in epilepsy is reviewed briefly with particular refe ence to therapeutic results obtained in the Seizu Section of the Psychiatric Out-Patient Clinic of th Grace-New Haven Community Hospital. Th summary is presented in full hope and awareness c the fact that it may be out-dated in the space of few years, possibly even months.

BIBLIOGRAPHY

1. Merritt, H. H., and Putnam, T. J.: Sodium diphen hydantoinate in the treatment of convulsive disorder J.A.M.A. 111:1068-73, (September), 1938.

2. Lennox, W. G.: The petit mal epilepsies, their treatmer with tridione. J.A.M.A., 129:1069-73, (December), 1945.

3. Loscalzo, A. E.: Treatment of epileptic patients with combination of 3-methyl 5, 5-phenyl-ethyl-hydantoin an phenobarbital. J. Nerv. and Ment. Dis., 101:537, (June) 1945.

4. Lennox, W. G., and Davis, J.: Acid diphenyl hydantoi and dioxazolidinedione. Presented at the Meeting of th International League against Epilepsy, American Branch Atlantic City, June 13, 1948.

5. Gibbs, F. A., Everett, G. M., and Richards, R. K. Phenurone in Epilepsy, Presented at the Meeting of th International League against Epilepsy, American Branch Atlantic City, June 13, 1948.

6. Penfield, W., and Erickson, T. C.: "Epilepsy and Cerebral Localization," Charles C. Thomas, Baltimore, Maryland 1941.

7. De Jong, R. N.: Effect of tridione in the control of psychomotor attacks. J.A.M.A., 130:565, 1946.

8. Davis, J. B., and Lennox, W. G.: The effect of trimethyl- oxazolidine dione and of dimethyl oxazolidine dione on seizures and on the blood. Res. Publ. Ass. Nerv. Ment. Dis., 26:423-36, 1946.

9. Kozol, H. L.: The treatment of epilepsy with methyl-phenyl-ethyl-hydantoin (mesantoin). Res. Publ. Ass. Nerv. Ment. Dis., 26:404-11, 1946.

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Postgraduate Education at Yale

Postgraduate courses at the Yale University School of Medicine for Connecticut practicing physicians were off to a good start in September and October with approximately 175 physicians enrolled in various courses by October 1. Most popular courses to date, judging by enrollment figures, are the Obstetrical Conference, Gastroenterology, Cardiovascular Disease, Pediatrics, Anatomy, and the Second Postgraduate Seminar in Neurology, Psychiatry and Related Fields of Medicine.

To aid the University in adequate planning for postgraduate work, physicians who wish to take courses are urged to enroll as far in advance as possible. Enrollment in certain courses scheduled for the Winter and Spring is progressing steadily, and these courses will probably be full long in advance of the date the course is scheduled to begin.

Closing dates for enrollment in most courses have been established approximately one month prior to the date the courses are scheduled to begin. Although late applications will be accepted when possible, preferential consideration will be given those applications received before the closing date.

There has been some confusion concerning the fee for the course in Metabolism, Medicine 202, offered for presentation in community hospitals upon invitation of the hospital staff. The $300 fee covers the entire group participating. It is not intended that each physician enrolled must pay $300. If twenty physicians participated and each paid equally, the cost would be $15 per physician. The hospital or local medical society could decide to pay for the course.

Application cards for courses, or the University Bulletin containing full information, may be obtained from the office of the assistant dean in charge of Postgraduate Education, Yale University School of Medicine, 333 Cedar Street, New Haven 11, Connecticut; Telephone 5-1161, extension 864.

Physicians interested in courses which are not offered this year are invited to write the assistant dean of their interests. Such letters will be helpful in planning next years' offerings.

Short courses scheduled to begin later in the year are listed below.

MEDICINE 200, CARDIOVASCULAR DISEASE

Twelve sessions of two hours each. March 10—May 26, 1949. Thursdays, 10-12 A. M. Drs. H. M. Marvin, A. J. Geiger, and others. Fee $45. Enrollments requested before February 1, 1949.

MEDICINE 202, METABOLISM

The metabolism section of the Department of Medicine is prepared to offer a course on metabolic diseases to be given at community hospitals, upon invitation from the hospital staff. The content and schedule of the course will be decided in consultation with the committee from the hospital staff. For the entire group of physicians enrolled, $300 for eight sessions. Dr. J. P. Peters and staff.

MEDICINE 203, NUTRITION AND DIET IN MEDICAL PRACTICE

A course covering basic principles of nutrition, problems of malnutrition in various clinical conditions, nutritional appraisal, and dietetics in medical practice. Twelve periods of two hours each beginning March, 1949. (Note the starting date has been advanced from January to March.) Fee $45. Drs. G. R. Cowgill, J. P. Peters, and staffs. Applications requested before February 1, 1949.

PATHOLOGY 200

Designed for practicing physicians to review the present status of etiology, pathogenesis, and life history of disease processes commonly encountered in practice. January 4—March 15, 1949. Tuesdays, 10-12 A. M. Minimum enrollment twenty. Fee $45. Drs. H. S. N. Greene, H. Bunting, A. A. Liebow, J. H. Milstone, L. L. Waters. Applications requested before December 1, 1948.

PEDIATRICS 200

Covers common problems in the care of children. Twelve sessions of two hours each. January 6—March 24, 1949. Thursdays, 10-12 A. M. Fee $60. Drs. G. F. Powers and staff, C. S. Amatruda, D. H. Clement, E. C. Curnen, D. C. Darrow, M. Y. Krosnick, P. R. Lurie, R. Whittemore. Applications requested before December 1, 1948.

PEDIATRICS 201, PEDIATRIC NEUROLOGY

Fridays, 6:30 to 10 P. M., April 8 through April 29, 1949, at the Southbury Training School, Southbury. Fee $15. Under direction of Dr. H. Yannet. Applications requested before March 1, 1949.

PSYCHIATRY 201, FUNDAMENTALS OF ANALYTIC PSYCHOLOGY AND PSYCHOPATHOLOGY

The course will consist of six lectures, each followed by a round-table conference. Fridays from 6:30 to 10 P. M. at fortnightly intervals, January 14 and 28, February 11 and 25, and March 11 and 25, 1949, at the Institute of Human Relations, New Haven. Fee $35. Dr. L. S. Kubie. Applications requested before December 15, 1948.

SURGERY 201, TRAUMATIC SURGERY

Twelve sessions of two hours each. January 19—April 6, 1949. Starting date advanced from January 5 as previously announced. Wednesdays, 9:45-11:45 A. M. Fee $45. Dr. A. W. Oughterson and others. Applications requested before December 1, 1948.

SURGERY 203, EARLY DIAGNOSIS OF CANCER

This course is arranged to emphasize the early detection of cancer rather than a detailed differential diagnosis of specific types. The subject will be covered by systems, and treatment will be considered from the standpoint of results rather than technique. Twelve sessions of two hours each.

March 25—June 10, 1949. Fridays, 3-5 P. M. Fee $45. Dr. S. C. Harvey and others. Applications requested before February 15, 1949.

THERAPEUTICS 200, MODERN DRUGS AND COMMON PROBLEMS IN THERAPY

This course is for practicing physicians and is concerned with common problems in therapeutics, with special reference to new forms of medicinal agents. These will be discussed in seminars jointly by a pharmacologist and a clinical specialist in each of the various fields. Among the groups of drugs to be considered are antibiotics, antihistaminics, sulfonamides, and synthetic substitutes for morphine. Eighteen sessions of two hours each. Among the clinical specialists who will participate are Drs. E. M. Blake, S. C. Harvey, H. M. Marvin and H. Thoms. February 1—May 31, 1949. Tuesdays, 7 to 9 P. M. Dr. W. T. Salter and staff. Applications requested before January 3, 1949.

CLINICAL NEUROLOGY

Twenty-seven lectures, including (a) Semiotics of Diseases of the Nervous System (five lectures), (b) Topics of Clinical Neurology with Medical Implications (nine lectures), (c) Topics of Clinical Neurology with Neurosurgical Implications (eight lectures), and (d) Neuroroentgenology (five lectures and demonstrations). Mondays 4 to 10 P. M., January 3 through February 28, 1949, at the Grace-New Haven Community Hospital, New Haven. Fee $20. Applications requested before December 15, 1948.

PSYCHIATRY

Twenty-seven lectures, including (a) Psychosomatic Medicine (nine lectures), (b) Clinical Psychology (six lectures), and (c) certain topics of Clinical Psychiatry and Pscyhiatric Therapy (twelve lectures). Mondays, 4 to 10 P. M., March 7 through May 2, 1949, as follows: Psychosomatic Medicine, March 7 through March 21 at the Grace-New Haven Community Hospital, New Haven; Clinical Psychology, March 28 and April 4 at the Institute of Human Relations, New Haven; and Clinical Psychiatry and Psychiatric Therapy, April 11 through May 2 at the Fairfield State Hospital, Newtown. Fee $20. Applications requested before February 15, 1949.

Note: Clinical Neurology, Psychiatry, Pediatric Neurology and Fundamentals of Analytic Psychology and Psychopathology are components of the Second Connecticut Postgraduate Seminar of Neurology, Psychiatry and Related Fields of Medicine. One can enroll for all of them at a fee of $75.

Will Braun of AMA Dies

Will C. Braun, business and circulation manager of the American Medical Association for 54 years, died in Presbyterian Hospital, Chicago, on September 12 of uremic poisoning. Mr. Braun was 80 years old and had retired as business manager of the AMA only this last July. During his tenure of office the circulation of the *Journal of AMA* rose from 3,500 per week to more than 115,000.

The AMA Session in St. Louis

All AMA Interim Session activities—meetings of the House of Delegates, general lectures, clinical presentations, scientific exhibits, technical exhibits, motion pictures and television—will be concentrated in the Kiel Auditorium in St. Louis. The AMA Interim Session will open in St. Louis on Tuesday, November 30, and continue through Friday, December 3.

The program includes a general session on Tuesday and Thursday evenings with outstanding entertainment on Wednesday evening. The second annual General Practitioner award will be presented on Thursday evening.

Registration will begin Tuesday morning and the meetings will close at noon on Friday.

The St. Louis Local Committee on Arrangements, which has been very active, is headed by Dr. Robert E. Schlueter and Dr. Llewellyn Sale, who is serving as co-chairman. Subcommittee chairmen are: Drs. Flavius G. Pernoud, hotels; Robert F. Hyland, transportation; Robert C. McElvain, information and registration, and Cyrus E. Burford, general meeting.

The Subcommittee on Scientific Meetings is headed by Dr. Alphonse McMahon, chairman, and Dr. Daniel L. Sexton, co-chairman.

The scientific program will begin at 2 P. M. Tuesday with two half-hour periods of lectures. After a brief recess, clinical presentations, many of them with patients, will be conducted in seven rooms in the Scientific exhibit hall. Exhibits pertaining to the clinical presentations will be shown in areas outside each room. The same procedure will be followed each morning and afternoon.

The program on diabetes will be in charge of Dr. Howard F. Root, Boston, with Dr. William H. Olmsted, St. Louis, serving as local chairman. Clinical presentations will be conducted from 10 A. M. to 1 P. M. and from 3:30 P. M. to 5 P. M. on Wednesday and Thursday. Dr. Elliott P. Joslin, Boston, will summarize the subjects at 9:30 A. M. on Friday.

The cancer program will be in charge of Dr. Brewster S. Miller of the American Cancer Society, New York, with Dr. Sherwood Moore, St. Louis, as local chairman. The general lecture on cancer will take place at 9 A.M. Friday and clinical presentations from 3:30 to 5 P. M. on Tuesday, Wednesday and Thursday.

The poliomyelitis program is being handled by

Catherine Worthingham of the National Foundation for Infantile Paralysis, New York, and Dr. Sedgwick Mead, St. Louis, is the local chairman. The program, which calls for elaborate presentations on the diagnosis and treatment of the diseases, will be repeated daily at 10:30 A. M. to 12 noon, and 3:30 to 5 P. M. The general lecture will be given at 2 o'clock on Thursday afternoon.

The program on cardiovascular diseases has been arranged by Dr. O. P. J. Falk, St. Louis, the local chairman. A general lecture on hypertension will be given at 2 P. M. Tuesday with clinical presentations from 3:30 to 5 P. M. A lecture on heart disease will be given at 2:30 P. M. Thursday with clinical presentations on Wednesday and Thursday afternoons from 3:30 to 5:00.

The subject of obstetrics will be confined largely to the problems of delivery. Dr. Arthur B. Hunt, Rochester, Minn., the coordinator, and Dr. Joseph A. Hardy, Jr., St. Louis, the local chairman, have arranged for clinical presentations on Tuesday, Wednesday and Thursday afternoons, with a general lecture at 2:30 P. M. Tuesday.

The clinical presentations on pediatrics will be conducted Wednesday, Thursday and Friday mornings from 10:30 to 12:00, with the general lecture at 9 A. M. on Wednesday. Dr. Hugh McCulloch is the coordinator and Dr. Peter G. Danis, St. Louis, the local chairman.

Laboratory diagnosis will be in charge of Dr. Frank W. Konzelmann, Atlantic City, and Dr. Robert A. Moore, St. Louis, is the local chairman. Clinical presentations will be given each morning and afternoon throughout the week, while continuous demonstrations will be conducted by members of the St. Louis Pathological Society in a laboratory adjacent to the clinic room. Dr. Konzelmann will present the general lecture at 9:30 Wednesday morning.

Dermatology, in charge of Dr. Clinton W. Lane, St. Louis, the local chairman, will be covered in clinical presentations on Wednesday, Thursday, and Friday mornings. The general lecture will be given at 2:30 P. M. Wednesday.

The program covering hematuria includes clinical presentations on Wednesday, Thursday and Friday mornings, with a general lecture at 9 o'clock Thursday morning. The coordinator is Dr. Edward N. Cook, Rochester, Minn., with Dr. Grayson Carroll, St. Louis, serving as local chairman.

The jaundice program is under the direction of Dr. Sidney A. Portis, Chicago, and Dr. R. O. Muether, St. Louis, is the local chairman. Clinical presentations will be conducted Thursday morning and afternoon and Friday morning. The general lecture will take place at 9:30 A. M. Thursday.

Clinical presentations on radiology will be covered Tuesday afternoon and Wednesday morning and afternoon and will be in charge of Dr. Paul C. Hodges, Chicago, as coordinator and Dr. Wendell G. Scott, St. Louis, as local chairman.

The subject of arthritis, under the direction of Dr. C. H. Slocumb, Rochester, Minn., with Dr. Ralph A. Kinsella, St. Louis, as local chairman, will be discussed in a general lecture at 2 o'clock Wednesday afternoon with clinical presentations on Tuesday afternoon from 3:30 to 5:00 and on Friday morning from 10:30 to 12:00.

With the cooperation of the St. Louis University School of Medicine and Washington University School of Medicine, television will be shown continuously. The committee in charge consists of the Rev. Alphonse M. Schwitalla and Dr. Robert A. Moore, St. Louis.

The Scientific Exhibit will consist of groups of exhibits covering all these subjects as well as miscellaneous topics. The exhibits have been carefully chosen for the interest to the physician in general practice.

Motion pictures will be shown daily from 12 noon to 3:30 P. M., with a carefully chosen list of films selected by the Committee on Medical Motion Pictures of the AMA.

George F. Lull, M.D.,
Secretary and General Manager

Kentucky's Prepayment Plan

The House of Delegates of the Kentucky State Medical Association voted in September, during a special session, on "The Kentucky Physicians Service." The plan provides for straight cash indemnity and is to be governed by the House of Delegates in a manner similar to that used by Michigan Medical Service. The members of the board of directors are to be selected by the House of Delegates with the eleven councilor districts each having a representative. Dr. Oscar O. Miller is chairman for the committee for the Study of Medical Care and Prepayment Plan.

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

JAMES G. BURCH
Public Relations

258 CHURCH STREET, NEW HAVEN
Telephones: 5-0249, 5-0836

CALL

SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1948 Semi-Annual Meeting of the House of Delegates will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Thursday, December 9, beginning at 3:00 o'clock in the afternoon.

Members of the House will be the guests of the Society at dinnner following the meeting.

Samuel C. Harvey, President
Creighton Barker, Secretary

COUNCIL RESUMES MEETINGS

The regular monthly meetings of the Council of the Society were resumed after summer recess on Thursday, September 30, 1948. There were present: the Chairman, Dr. Murdock, Drs. Bishop, Burlingame, Gibson, Harvey, Howard, Parmelee, Speight, Sprague, Walker, Barker, Miss Mooney. Absent: Drs. Gildersleeve, LaMoure, Weld.

Plans for Headquarters Building

It was reported that working drawings for the Society's headquarters are nearly complete and that some bids may be ready to present to the Council at its next meeting. The total amount pledged to the Building Fund has now passed $80,000, and nearly $10,000 of this sum is made up of memorial and special gifts. The number of members who have contributed to date is 1,155.

NOMINATING COMMITTEE

The Chairman of the Council was authorized to appoint a Nominating Committee which will make proposals to the Council for nominations of officers and committee members for 1949-50 and the secretary was directed to prepare nomination schedules and distribute them to the secretaries of the county medical associations in order that the associations might also send in suggestions for nominations.

1949 BUDGET

The committee to make recommendations to the Council for the 1949 budget and amount of dues to be assessed was appointed by the Chairman and the committee consists of Dr. Gibson, Chairman, Dr. Weld and Dr. Barker.

BY-LAW REVISIONS RECOMMENDED

Article VI, Section 2. Par. 3. The Vice-President shall assist the President in the discharge of his duties and in the absence of the President or upon his request shall assume the duties of the office. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the term by the first Vice-President. In the event of a vacancy in the office of President-Elect, the first Vice-President shall succeed to that office and the office of first Vice-President shall be assumed by the second Vice-President.

Article VI, Section 2. Par. 7. In the event of a vacancy in the offices of Executive Secretary, Treasurer or Editor-in-Chief of the JOURNAL, the vacancy shall be filled by a member of the Society appointed by the Council to serve until the next annual or semi-annual meeting of the House of Delegates.

Article VIII, Section 1. Par. 3. The presiding officer of the House of Delegates may, in his discretion, appoint committees, to be known as reference committees, from the membership of the House

which business or reports presented before the louse may be referred for review and recommendaons.

EW COMMITTEE APPOINTMENTS

Dr. Alexander J. Tutles, Bridgeport, was appointed a member of the Committee on Chronically l.

At the request of the Chairman of the Joint Conerence Committee with the Connecticut Pharmaeutical Association, Dr. Alfred Labensky, New ondon, and Dr. George A. Buckhout, Bridgeport, ere added to this committee.

EPORT ON UNIFORM FEE SCHEDULE

Dr. Gibson presented the report of the Special ommittee to Study Plans for a Uniform Fee chedule for Private Professional Services Purchased y the State of Connecticut appointed by the Comissioner of Finance and Control. The Council had lesignated a special advisory committee to work vith the state committee. The Council voted approval of the report presented by Dr. Gibson and ie was directed to prepare an abstract of its content for publication in the CONNECTICUT STATE MEDICAL JOURNAL.

ADDITIONAL BUDGET ALLOTMENTS

An additional allotment of $200 was voted for the budget of the Committee on Public Relations.

An additional allotment of $50 was voted for the budget of the Committee on Industrial Health.

NATIONAL DIABETES WEEK

The Council voted endorsement of National Diabetes Week, December 6-12, 1948, and the delegates to the American Medical Association were instructed to support a resolution endorsing National Diabetes Week which will be presented to the House of Delegates of the American Medical Association at the interim session in St. Louis, on November 30, 1948.

SUB-COMMITTEE ON HEART DISEASE

The request of the Committee on Public Health that it be authorized to appoint from its membership a Sub-Committee on Heart Disease was approved.

STUDENT MEMBERS

The following residents of Connecticut who are now studying medicine were elected to Student Membership of the Society:

Joseph Angelica, Thompsonville
Tufts College Medical School—Class of 1950
Pre-Med: American International College
Parent: Nicolo Angelica

Jerome Bernstein, Bridgeport
Georgetown Medical School—Class of 1951
Pre-Med: Johns Hopkins University
Parent: Abraham Bernstein, M.D.

Howard R. Blight, Bridgeport
New York Medical College—Class of 1951
Pre-Med: Duke University
Parent: Charles H. Blight

Joseph R. Gionfriddo, Hartford
Georgetown Medical School—Class of 1951
Pre-Med: Trinity College
Parent: Paul Gionfriddo

Gilmer B. Johnson, Jr., Manchester
Northwestern University—Class of 1951
Pre-Med: Sulross State Teacher's College
Parent: Gilmer B. Johnson

Pauline E. Sullivan, Glastonbury
Woman's Medical College—Class of 1950
Pre-Med: University of Pennsylvania
Parent: John D. Sullivan

Peter J. Wick, Jr., Ridgefield
New York Medical College—Class of 1949
Pre-Med: Kenyon College
Parent: Peter J. Wick

The next meeting of the Council will be on Tuesday, November 9.

Meetings Held During October

Thursday, October 7, 4:30 P. M.
Program Committee

Tuesday, October 12, 6:00 P. M.
Prepaid Medical Service Sub-Committee

Wednesday, October 13, 4:00 P. M.
Committee for the Improvement of the Care of the Patient

Friday, October 22, 5:30 P. M.
Budget Committee

Meetings Scheduled for November

Thursday, November 4, 3:00 P. M.
Committee on Public Health

Tuesday, November 9, 10:00 A. M.
Regular written examinations of the Connecticut Medical Examining Board, State Capitol, Hartford

Wednesday, November 10, 9:00 A. M.
Regular written examinations of the Connecticut Medical Examining Board, State Capitol, Hartford

Monday, November 15, 5:00 P. M.

Committee on Cooperation with the Yale School of Medicine, Graduates Club, New Haven

Meetings Scheduled for December

Thursday, December 9, 3:00 P. M.

Semi-Annual Meeting of the House of Delegates, New Haven Medical Association

Professional Liability Insurance

A substantial proportion of the members of the Connecticut State Medical Society hold professional liability insurance under the group contract written especially for the Society by the Aetna Casualt and Surety Company. Relatively few, howeve realize how favorable this contract is.

Recently the secretary's office sent inquiries to number of insurance companies listed with th American Medical Association as writers of ma practice insurance. Several of the firms replied tha they did not write this line but seven quoted rat for various limits of coverage. These rates illustrat strikingly the advantage of being insured under th Society group contract. The dollar saving is, in fac almost exactly equal to the membership dues of th State Society.

All of the premium rates obtained are quoted fo various limits in thousands of dollars.

THOUSANDS OF DOLLARS	10-25	15-25	15-30	20-40	20-60	25-50	25-75	30-60	50-100	75-15
Conn. State Medical Society Group	12.50	16.75	17.00	18.13	18.88	19.13	19.75	19.88	22.25	24.0
Company A (Rates do not apply to specialists in surgery)	32.00	33.50	34.00	36.25	37.75	38.25	.....	.....	.....	.....
Company B—Physicians	32.00	33.50	34.00	36.25	37.75	38.25	39.50	39.75	44.50	.....
Surgeons	40.00	41.90	42.50	45.30	47.20	47.80	49.40	49.70	55.60	.....
Company C—Physicians (Rates are increased 25 per cent for surgeons)	32.00	33.50	34.00	36.25	37.75	38.25	39.50	39.75	44.50	.....
Company D—Physicians	32.00	33.50	34.00	36.25	37.75	38.25	39.50	39.75	44.50	48.75
Surgeons	38.40	40.20	40.80	43.50	45.30	45.90	47.40	47.70	53.40	58.50
Company E	32.50	.....	.....	.....	38.25	.....	40.00	.....	46.25	.....
Company F—Physicians	38.40	40.20	40.80	43.50	45.30	45.90	47.40	47.70	53.40	.....
Surgeons	51.20	53.60	54.40	58.00	60.40	61.20	63.20	63.60	71.20	.....
Company G—Physicians	38.40	40.20	40.80	43.50	45.30	45.90	47.40	47.70	53.40	.....
Surgeons	51.20	53.60	54.40	58.00	60.40	61.20	63.20	63.60	71.20	.....

Medicine of the Year

In the September and October numbers of the CONNECTICUT STATE MEDICAL JOURNAL, announcement was made of *Medicine of the Year*, the annual review of medical progress offered to members of the Connecticut State Medical Society as a supplement to their JOURNAL. For the benefit of those members who may have failed to notice it, or as yet failed to subscribe, the announcement is repeated in this issue of the JOURNAL in the belief that the review contributes a valuable educational opportunity at little cost which the Society, through its JOURNAL, has made available to its members.

Recent information from the editorial office of *Medicine of the Year* indicates that the plan for the review is proving popular in the states where it has already been announced. Additional states are planning announcements soon.

Recently the associate contributors for the various medical specialties, a group of distinguished authors and nationally known authorities in their fields, have been selected. They are the following:

Allergy: Dr. Harry L. Alexander, Washington niversity, St. Louis.

Pulmonary disease: Dr. J. Burns Amberson, Belle- ue Hospital and Columbia University, New York.

Metabolism and endocrinology: Dr. Kendall merson, Jr., Peter Bent Brigham Hospital, Boston.

Dermatology: Dr. Chester N. Frazier, Harvard niversity and Massachusetts General Hospital, oston.

Cardiovascular diseases: Dr. William J. Kerr, Uni- ersity of California and University Hospital, San rancisco.

Neurology: Dr. H. Houston Merritt, Montefiore lospital, New York.

In order to provide this service, it is necessary iat a minimum number of subscriptions be entered nd each member is urged to send in the coupon vithout delay. No obligation is incurred if an in- ufficient number is secured and if an adequate umber is secured you can be assured of a valuable id at nominal cost. *Subscribe now.*

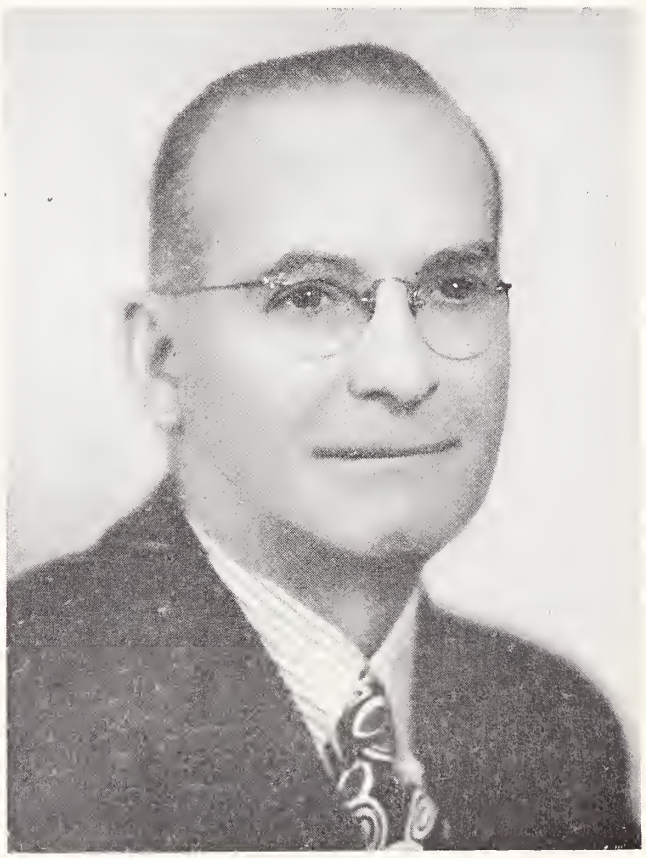
Changes at Norwich State Hospital

The Board of Trustees of the Norwich State Hos- ital announce the appointment of Dr. Ronald H. Cettle as superintendent of the hospital. Dr. Kettle's ppointment became effective on August 25, 1948. Prior to taking over the duties of the superintend- ncy, Dr. Kettle had been acting superintendent ince July 28, 1948 when Dr. Riley H. Guthrie esigned the superintendency. Dr. Kettle had pre- iously been assistant superintendent of the hospital ince February 19, 1941, except for a period of 41 nonths beginning October 1942 when he volun- eered for military service and became a flight urgeon in the U. S. Air Force. His military service ncluded overseas duty in the Asiatic Pacific theater. n March 1946 Dr. Kettle was honorably discharged with the rank of lieutenant colonel and returned to his position at the Norwich State Hospital.

The Board of Trustees also announce the appoint- ment of Dr. Conrad O. Ranger as clinical director of the hospital, and he will begin his new duties at the hospital on October 1, 1948. Dr. Ranger who has been consultant for the Veterans Administration at Manchester, N. H., until the present time, was for- merly a senior physician, psychiatrist on the medical staff of the Norwich hospital from July 1940 until July 30, 1941 when he went into private practice of neurology and psychiatry at Concord, N. H. In July 1942 he enlisted in the U. S. Army and saw service in England and France. He was honorably discharged from the Army in June 1946, with the rank of lieutenant colonel and had been serving as psychiatric consultant for the Seine Section of France.

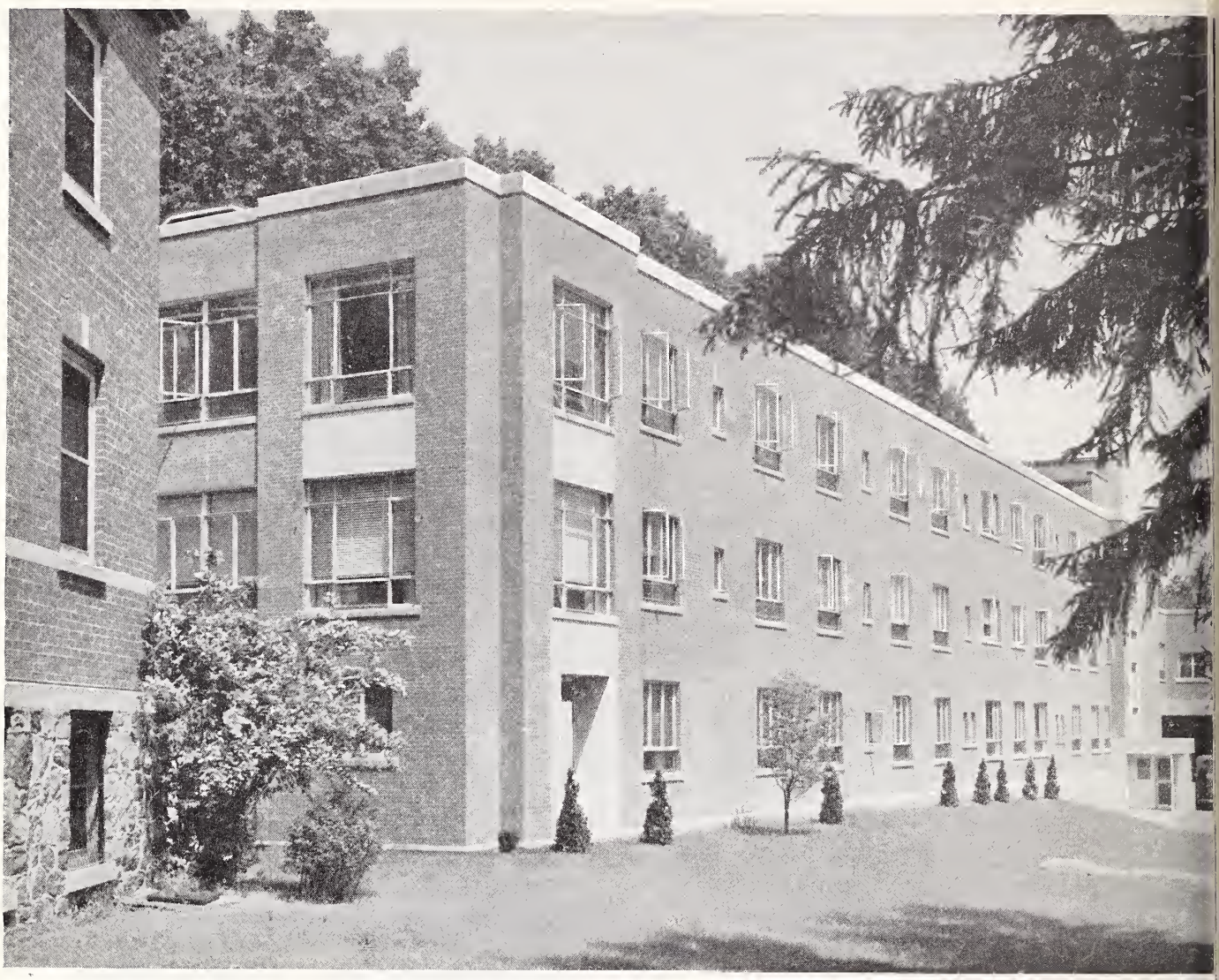
Both Dr. Kettle and Dr. Ranger are diplomates of the American Board of Psychiatry and Neurology.

First President Connecticut General Practice Group



Michael S. Shea, M.D.

Michael S. Shea, New Haven, recently elected first president of the Connecticut Chapter, American Academy of General Practice, is a member of the attending staff, Hospital of St. Raphael. He received his medical degree at the University of Vermont Medical School in 1921, and has practiced medicine in New Haven since 1922. A member of the New Haven County Medical Association, and state and national medical organizations, Dr. Shea holds membership in the American College of Chest Physicians, the American Trudeau Society, and the Advisory Council of the New Haven Tuberculosis Association.



Barnes Memorial Building — Bristol Hospital

The Barnes Memorial Building was opened for patients and services during the first week of April, 1948. This building, erected at a cost of approximately $750,000, embodies the latest in hospital building. This addition will be used primarily for medical service. Completely soundproof throughout and with all walls tastefully decorated with a modern wall covering called Fabron, the entire buildin is the last word in efficiency and convenience.

When the new obstetrical wing is complete a well as some structural changes in the old building Bristol Hospital will be one of the finest 200 be hospitals in New England.

Clinical Congress Breaks Record

The 1948 Clinical Congress, held in New Haven September 14, 15 and 16, surpassed all attendance records in its twenty-three year history.

Actual registrations numbered 794, and it is estimated that those who attended some of the afternoon sessions without registering brought the total attendance well above 800. All of the clinical presentations and panel discussions during the three day session were well attended, and at several of the afternoon meetings it was necessary to provide additional seating capacity.

The Congress is sponsored annually by the Stat Medical Society in cooperation with the Yal University School of Medicine. The committe which planned the Congress this year was heade by Herbert Thoms, New Haven, acting chairman and Cole B. Gibson, Meriden, treasurer. Other mem bers, all from New Haven, included Hugh L Dwyer, David H. Clement, Barnett Greenhouse C. Stanley Hitchins, Arnold H. Janzen, Burness E Moore, Max Taffel, and William R. Wilson.

Cancer Society Annual Meeting

Dr. Creighton Barker, State Medical Society ecutive secretary, was re-elected president of the nnecticut Cancer Society at the organization's nual meeting Wednesday, September 29, at the aterbury Country Club. Dr. Joseph H. Howard, idgeport, was elected vice-president; Miss Grace ooney, executive assistant of the State Medical ciety, secretary; Charles F. Lewis, Waterbury, easurer; and Mrs. Douglass O. Burnham, Waterwn, Field Army chairman.

The meeting was attended by approximately 125 embers of the Society, and was reported to be the rgest ever held. Samuel C. Harvey, State Medical ociety president and head of the Department of ncology, Yale University School of Medicine, was uest speaker at a dinner following the business ssion.

The expansion of research, both fundamental and pplied, contains the greatest hope for success in the ght against cancer, Dr. Harvey declared. He mphasized that service without research is static nd ineffective, and cited the valuable advances in esearch methods accomplished during the past few ears. Coordinated departments in cancer research ave now been established in all but nine of the ation's 77 medical schools, aided by appropriations f the United States Public Health Service, he told Society members.

One of the first tasks of these departments is the furthering of scientific method by forsaking older methods of didactic teaching and instituting a more effective process of laboratory experimentation and study. This new procedure, Dr. Harvey explained, supports the mission of real education by providing students with opportunities for accomplishment as well as learning. Students are thus motivated through conviction that problems and their solutions in the field of cancer research are controversial and subject to the challenge of new knowledge.

Dr. William U. Gardner, professor of anatomy, Yale University School of Medicine, was elected chairman of the Society's Medical Advisory Committee, and other committee chairmen were elected as follows: Robert I. Laggren, Middletown, Campaign Planning Committee; Dr. Charles C. Wilson, Yale professor of education and public health, Public Education Committee; Mrs. George P. Milmine, Lakeville, Social Service Committee; and Charles F. Lewis, Waterbury, Finance Committee.

In his annual report Dr. Barker stated that public interest and knowledge of cancer has increased more rapidly than in any other health field, a recent Gallup Poll indicating that 57 per cent of the people fear and dread cancer more than any other disease. "It is in this atmosphere of public concern and human interest that the Connecticut Cancer Society operates," he said, and estimated that, except for hospitals, the organization is now probably the most substantial voluntary health agency in the State. During the year 1947-1948 requests for allotment of funds exceeded those available by approximately $50,000, Dr. Barker reported. He paid tribute to the untiring efforts of Society officers and volunteer workers, and recommended that the effectiveness of these services be assured through a study of the aims and objectives of the organization.

General Practitioners Organize Chapter A. A. G. P.

Michael S. Shea, New Haven, was elected president of the Connecticut Chapter, American Academy of General Practice, at the first annual meeting of the organization, held in New Haven September 15. Michael W. Palmieri, New Haven, was named president-elect of the new organization, and Peter J. Scafarello, Hartford, was elected secretary-treasurer.

The meeting followed a luncheon at the Towne House, and was attended by 65 members and guests. Julius Grower, Middletown, retiring temporary chairman, was elected to membership on the Board of Directors. Other directors named were Edwin F. Trautman, Bridgeport; Albert W. Dautrich, Litchfield; and John J. Freeman, Newington.

In accepting office as first president of the Connecticut Chapter, Dr. Shea expressed his appreciation of the honor conferred upon him and urged that the formation of county groups be speeded so that complete organization will be effected by next spring.

The new program of postgraduate medical education instituted at the Yale University School of Medicine in cooperation with the Connecticut State Medical Society and its value to members of the Academy of General Practice was the subject for discussion following the business session.

Principal speakers were William R. Willard, Yale's assistant dean in charge of postgraduate medical education; Ashley W. Oughterson, professor of

surgery; Herbert Thoms, professor and chairman of the Department of Obstetrics and Gynecology; Samuel D. Kushlan, professor of medicine; and William U. Gardner, professor of anatomy.

Organizational progress of the Connecticut Chapter was reviewed by Dr. Palmieri and Dr. Grower. The first local chapter of the organization has been chartered in Litchfield County, and applications for charters are soon to be received from groups in Middlesex and Hartford counties, Dr. Palmieri said. Pending complete organization of the county chapters, it was pointed out that applications for individual membership should be mailed to Dr. Peter J. Scafarello, 410 Asylum Street, Hartford.

Connecticut Society of American Board of Surgeons Organizes

The organization meeting of the Connecticut Society of the American Board of Surgeons was held in Hartford September 23. At this time a business meeting was held at the Hunt Memorial Building, a social hour at the Hartford Club, dinner at the Hartford Club, and the evening speaker was Allen O. Whipple, director of research at the Memorial Hospital.

The by-laws of the Connecticut Society of the American Board of Surgeons, Inc., were unanimously passed. There were approximately 100 members present. The officers elected for the year were Edward Ottenheimer, president; Ashley Oughterson, vice-president; Courtney C. Bishop, treasurer and secretary. The first annual meeting is to be held in December 1948, and yearly thereafter.

Is the Prescription Expensive?

Patients who are advised by their physicians concerning the cost of prescriptions frequently misunderstand the situation if the price quoted by the pharmacist is at variance with the given figure.

This problem was discussed at length at the October meeting of the Joint Council on Pharmacy and Medicine of the State Medical Society and the Connecticut Pharmaceutical Association. A resolution was passed to the effect that when a drug prescribed is known to be expensive the patient should be so advised, but without indication of the probable cost. It was pointed out that in many cases patients ar overly insistent that some indication of price b given by the physician when the prescription written. However, the committee concluded tha the fairest policy, and the one which could con tribute best to clear understanding, would be t refrain from giving information beyond mentionin whether the prescription may be expensive or inex pensive.

The text of the resolution: "A physician shoul not attempt to estimate the likely cost of a prescrip tion. It is unfair to the pharmacist and is comparabl to the pharmacist attempting to prejudge a physi cian's fee. It is advisable, however, that when a dru prescribed is known to be expensive the patien should be so advised."

Dr. Moulyn to Stamford Alcoholics Clinic

Appointment of Adrian C. Moulyn as staff psychiatrist of the new clinic for the care and treatmen of alcoholics at Stamford has been announced by Dr. Dudley Porter Miller, executive director of the Connecticut Commission on Alcoholism.

Dr. Moulyn graduated from the Medical Schoo of the University of Utrecht, Holland, in 1930, and has since pursued graduate studies in several fields of medicine and has engaged in practice in Holland, Netherlands West Indies, and Massachusetts. Following a position on the staff of the Danvers State Hospital in Massachusetts and subsequent psychiatric work in a well known private hospital in the same State, he joined the faculty of the Yale University Medical School where he gave instruction in psychiatry. He comes to Stamford directly from the Yale Plan Clinic at New Haven.

Dr. Francis Lundborg Appointed to Trinity Faculty

Francis L. Lundborg of West Hartford has been appointed medical director at Trinity College, to succeed Horace C. Swan who retired in June. Dr. Lundborg who assisted Dr. Swan in the health program for Trinity students since 1935 was graduated from Trinity in 1924 and from Yale Medical School in 1930. Since his graduation Dr. Lundborg has practised in West Hartford. During World War II he served in the U. S. Army Medical Corps.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
airfield County, John G. Frothingham, New Canaan
lartford County, James R. Cullen, Hartford
itchfield County, W. Bradford Walker, Cornwall
liddlesex County, Richard F. Grant, Cromwell
lew London County, Edmund L. Douglass, *Chairman*
Groton
lew Haven County, Charles T. Flynn, New Haven
'olland County, William Schneider, Rockville
Vindham County, William S. Maurer, Willimantic



PUBLIC AFFAIRS

STATE OF CONNECTICUT
DEPARTMENT OF FINANCE AND CONTROL

JAMES B. LOWELL, *Commissioner of Finance and Control*

Effective October 1, 1948 the attached fee schedule will govern the payment for professional medical services by all institutions, departments and agencies of the State of Connecticut.

In November 1947 the Commissioner of Finance and Control appointed a committee to study plans for a uniform fee schedule for private professional services purchased by the State of Connecticut. This committee consisted of:

Chairman, Dr. C. B. Gibson, Medical Director, Undercliff Sanatorium; Mr. Robert J. Smith, Commissioner of Welfare; Dr. Stanley H. Osborn, Commissioner of Health; Col. R. F. Gates, Commandant, State Veterans Home and Hospital; Mr. E. P. Chester, Director of Vocational Rehabilitation.

The report of this committee has been approved by the Council of the Connecticut State Medical Society and by all State agencies concerned. Essentially the report is as follows:

PROFESSIONAL MEDICAL SERVICES FURNISHED BY PRIVATE PHYSICIANS UPON THE FINANCIAL RESPONSIBILITY OF THE STATE OF CONNECTICUT

The State of Connecticut utilizes private professional services in extensive and diversified activities. This is particularly true in the field of medical services. Many departments and institutions make use of the services of private physicians under varying circumstances; in varying endeavors in the field of health, in areas with varying economic levels, and at varying rates of remuneration.

On behalf of the State, medical services are rendered to many people who are entirely indigent, to some who are partially or medically indigent, and to others who, without regard to their economic status, are recipients of State programs designed to promote and maintain a healthful and physically efficient population.

The character of medical services provided by the State in these several categories varies from the ministrations of the general practitioner, in home or office, to the attention given by specialists in their respective fields, to the highly technical services required of certain physicians or surgeons who are qualified to perform certain unusual procedures.

Under all circumstances mentioned, the provision of medical care by the State is a financial responsibility assumed by the State through its various departments and institutions. In some instances, federal funds are available for some portions of the over-all expenditures, but the basic financial responsibility for all of these services belongs to the State of Connecticut. In the final analysis the funds used to remunerate physicians for services rendered through Connecticut agencies to the people of Connecticut come from the taxpayers of Connecticut.

It was agreed that the following are fundamental considerations for the establishment of a uniform fee schedule for State agencies:

1. That wards of the State, temporarily or permanently indigent, or medically indigent, are entitled to adequate medical care; and that programs for the maintenance and/or restoration of health and physical efficiency of the population are essential.

2. That those who render professional services in these endeavors should be satisfactorily and promptly remunerated.

3. That professional fees paid by the State should

be at lower rate than that expected of people of average income because:

A. Most of the people for whom the State pays fees are either medically indigent or have no income.

B. A physician will collect 100 per cent of his bills against the State, a percentage not universally attained in other fields of practice. In most instances the average collection per State patient at a lower rate will be more favorable than the average collection per private patient.

4. That professional fees in remuneration for services, as far as possible, should be computed upon a uniform basis for all agencies, weighting the value of service only upon the character or quality of the service rendered without regard to the agency or program under which it is performed.

In the development of a uniform fee schedule consideration was given to these basic features:

1. Reasonable fees for professional services that are acceptable to the medical profession, to the agencies contracting for such services, and to the fiscal authorities of the State.

2. Proportionate valuation of services depending upon the nature of the procedure performed. For example, there should be reasonable proportionate valuation as between a routine house call, an appendectomy, and an electrocardiographic study.

3. A flexible method for monetary valuation of services to meet ever changing economic conditions.

In attempting to devise a plan that would embody these three features the Committee has studied a number of fee schedules used by other states, and certain other schedules that have been approved by agencies of the federal government. Also, it has studied the indemnity schedules of various prepayment medical plans, both those sold on a non profit basis and those sold by commercial insurance carriers.

In general, these schedules were designed for people in moderate circumstances: that is, for a single person whose income does not exceed $1,800 and for a married person whose income is not in excess of $3,000. Using the average monetary fees for specific procedures it was decided to establish a unit value for any specific procedure in proper comparative relationship to any other procedure.

In this unit valuation, for instance, an appendectomy was valued at 1,000 units and an office call at 30 units. At 10 cents per unit, people in moderate circumstances, as above, would pay $100 for an appendectomy and $3 for an office call. To provide flexibility, if the income level of an individual is higher than the above ranges the monetary value of the unit can be raised to 12 or 15 cents, or higher, and below these incomes it is fair to assume that an individual is medically indigent and that medical services must be furnished by the State or other agency, and the rate can be set below 10 cents per unit.

By simply changing the unit value the whole schedule can be adjusted without altering its established relationship. The Committee has agreed to recommend that 8 cents be set as the monetary valuation per unit for procedures when the State pays for professional services. This valuation can be altered to meet changed economic conditions.

Following is the schedule of fees for calls by non specialists and specialists, and certain other services. Both unit valuation and the actual monetary fee are shown. For ease in computing, any procedure rating less than 100 units is multiplied by 8 cents per unit and then brought to the nearest 50 cents or even dollar.

This schedule does not cover all of the medical services now paid for by the State of Connecticut. It does embrace, however, from a quantitative and expenditure basis the majority of such services. Certain specialized fields have yet to be covered.

Fee Schedule

NON SPECIALSTS

VISITS AND EXAMINATIONS

Initial routine call and subsequent routine calls:

	UNITS	FEE
Office	30	2.50
Home	45	3.50
Convalescent and Boarding Home	45	3.50
For each additional patient	25	2.00
Night (7 P. M. to 7 A. M.)	80	6.50
Complete general routine examination including routine urinalysis and blood for serology:		
Office	50	4.00
Home	60	5.00
If written report required:		
Office visit and written report	60	5.00
Home visit and written report	75	6.00
Examination for commitment of mentally ill	60	5.00

SPECIALISTS*

(Internist, surgeon, pediatrist, ophthalmologist, otolaryngologist, orthopedist, cardiologist, etc.)

*Certified by an American Board of Specialists or by a State Medical Society.

ROUTINE EXAMINATIONS

	UNITS	FEE
Initial visits:		
Office	75	6.00
Home	85	7.00
Convalescent or boarding home	85	7.00
State owned and/or controlled institution	85	7.00
For each additional patient	35	3.00
Night	105	8.50
Subsequent visits:		
	UNITS	FEE
Office	50	4.00
Home	60	5.00
Night	105	8.50
If written report required:		
Office visit and written report	90	7.50
Home visit and written report	105	8.50

Attending Physicians

TO STATE OWNED OR STATE CONTROLLED INSTITUTIONS

Attending physicians shall be appointed by the governing authority of those State institutions requiring the services of private physicians for period visits to conduct ward round and/or clinic.

	UNITS	FEE
Visit	310	25.00

Attending Physicians

TO STATE OWNED OR STATE CONTROLLED INSTITUTIONS

Physicians who perform diagnostic, therapeutic, or operative procedures in State owned and/or State controlled institutions shall be compensated on a per patient basis of 80 per cent of the scheduled fee as listed for such procedures in the fee schedule of the Prepayment Medical Plan of the Connecticut State Medical Society. Until a final plan and fee schedule has been adopted by the State Medical Society, the schedule tentatively proposed at the meeting of the House of Delegates of the State Medical Society in December 1947 shall govern. When the new schedule has been adopted it shall apply, as shall any subsequent alterations, computed at 80 per cent for each scheduled item. (A copy of this tentative schedule is attached hereto.)

Concurrent Services

If two or more services are performed on the same patient concurrently by the same physician, the fee for the two or more concurrent procedures will be the greater or greatest fee plus one half each of the smaller fee or fees.

GENERAL SURGERY—INFECTIONS AND TRAUMATA

Abscess incision and drainage, furuncles excepted	$ 5.00
Deep cervical abscess	25.00
Carbuncle	25.00
Ulcer, surface excision	10.00
Tendon, repair, one primary	25.00
each additional	10.00
maximum	100.00
Septic finger (tendon sheath involvement)	15.00
Septic hand (tendon sheath and compartments)	75.00
Lacerations, extensive, including debridement	25.00

CYSTS

Cyst, sebaceous, removal	$ 10.00
Pilonidal cyst or sinus	50.00
Thyroglossal cyst, removal	100.00
Bronchial cyst, removal	100.00

TUMORS

Tumors, benign external, removal	$ 10.00
Tumors, benign, removal deep	25.00
Epulis, removal	15.00
Parotid tumor, removal	75.00
Epithiolioma of face, surgical removal	25.00
Cancer of tongue, (resection or removal)	100.00
Same with neck dissection	150.00
Cancer of lip (local operation)	35.00
Same with neck dissection	125.00

BIOPSY

Biopsy, superficial	$ 5.00
Biopsy, bone or bone marrow	15.00
Biopsy, needle aspiration	5.00

GLANDS

Glands, superficial, removal	$ 10.00
Dissection glands of neck, deep chain	100.00
Radical axilla or groin	100.00

THYROID

Thyroidectomy, subtotal	$125.00
Ligation preliminary to thyroidectomy	25.00
Thyroidectomy, two-stage, subtotal (with or without ligation) complete procedure	$150.00
Parathyroidectomy	150.00

BREASTS

Breast abscess, drainage	$ 25.00
Breast cyst or abscess, aspiration	10.00
Breast, tumor, benign, removal	35.00
Breast, radical removal, including axillary dissection	125.00
Breast, simple removal	75.00

MISCELLANEOUS

Ligation, saphenous vein, low, including retrograde injection, if done	$ 25.00
Ligation, saphenous vein, high (and combined) including retrograde injection, if done	40.00
Extensive varicose veins, one leg	50.00
(Multiple ligations on same or successive days)	
Same, bilateral	100.00
Toe nail, ingrown, removal, radical	20.00
Stone, submaxillary or parotid duct	25.00
Removal of submaxillary salivary gland	50.00
Injection, varicose veins, complete procedure	25.00

ENDOSCOPY

(When preliminary and related to surgical service only)

Bronchoscopy, diagnostic, preceding surgery	$ 25.00
Operative	50.00
Cystoscopy	
Observation (preceding surgery)	15.00
Ureteral catheterization	20.00
Operative	35.00
Gastroscopy	25.00
Laryngoscopy	
Diagnostic (by laryngoscope)	10.00
Operative	25.00
Peritoneoscopy	25.00
Sigmoidoscopy and biopsy	10.00
Esophagoscopy	25.00

SPECIAL SURGERY—THORACIC SURGERY

Pneumolysis	$ 75.00
Pleura, paracentesis	10.00
Empyema, closed drainage	25.00
Empyema, rib section	75.00
Phrenic nerve, crushing	25.00
Thoracoplasty (First stage or partial)	75.00
Complete	150.00
Lobectomy	150.00
Aneurysmorraphy	150.00
Induction of artificial pneumothorax	25.00
Refills	5.00

ABDOMINAL SURGERY

Abdomen, paracentesis	$ 10.00
Herniotomy, single inguinal, femoral or umbilical	100.00
Herniotomy, bilateral inguinal or femoral	125.00
Herniotomy, hiatus or diaphragmatic	150.00
Herniotomy, ventral or incisional	100.00
Esophageal diverticulum	125.00
Gastrotomy or gastrostomy	100.00
Gastrectomy	150.00
Gastro-enterostomy	125.00
Peptic ulcer, perforated, closure	100.00
Peptic ulcer, subtotal gastrectomy	150.00
Pyloric stenosis (Rammstedt's in infant)	100.00
Intestines, anastomosis	125.00
Intestines, (small) resection	125.00
Adhesions, freeing of	100.00
Laparotomy	75.00
Colon, resection	150.00
Colostomy	75.00
Appendectomy	100.00
Diverticulum, intestinal	100.00
Appendiceal abscess, drainage	100.00
Subdiaphragmatic abscess	100.00
Cholecystectomy	125.00
Biliary surgical drainage, common duct and cholecystectomy	150.00
Common duct, resection or reconstruction	150.00
Cholecystostomy	100.00
Cholecystoduodenostomy	125.00
Pancreas, drainage	100.00
Splenectomy	150.00

PROCTOLOGY

Hemorrhoids, injection treatment, complete procedure	$ 25.00
Hemorrhoid, thrombosis, incision	5.00
Hemorrhoids, internal	35.00
Hemorrhoidectomy	35.00
Fistulectomy, single, excision of tract	50.00
Multiple, excision or tract	75.00
Fissurectomy	10.00
Polypectomy	25.00
Abscess, ischiorectal or perirectal drainage	20.00
Carcinoma of rectum, resection	150.00
Perianal abscess, drainage	5.00
Prolapsed rectum, repair	100.00

UROLOGY

Circumcision, infant not requiring anesthesia	$ 5.00
Circumcision, excepting the above	15.00
Urethrotomy, external, except meatotomy	50.00
Urethrotomy, internal	50.00
Prostatic abscess	35.00
Prostatectomy, perineal	125.00
Prostatectomy, suprapubic—one stage including vasectomy	125.00
Prostatectomy, suprapubic—two stage including vasectomy	150.00
Prostatectomy, transurethral	100.00
Punch operation with suprapubic drainage	100.00
Perineoplasty with urethral repair	75.00
Hydrocele, radical operation	50.00
Litholapaxy	50.00
Epididymectomy	50.00
Vasectomy (when not preliminary to prostatectomy)	25.00
Vesiculectomy	100.00
Varicocelectomy	50.00
Orchidopexy—one stage	75.00
Two stage	125.00
Orchidectomy simple	50.00
With gland dissection	100.00
Cystotomy or Cystostomy	75.00
Cystostomy with fulguration	100.00
Cystectomy	150.00
Ureter transplantation, single	100.00
Bilateral	150.00
Bladder tumor, diverticula, etc. (resection)—open operation	125.00
Uretero-lithotomy	100.00
Nephrotomy	125.00
Nephrostomy	125.00
Nephrectomy	125.00
Nephropexy	100.00
Pyelotomy	100.00
Plastic on pelvis and ureter	125.00
Heminephrectomy	125.00
Excision and suture of urinary fistula (suprapubic)	50.00
(vaginal)	100.00
Penis amputation	75.00
Same with groin dissection	150.00
Plastic hypo--and epispadias	125.00
Meatotomy	5.00
Caruncle excision	15.00
Caruncle fulgeration	15.00

UROSURGERY—SKULL

nple fracture, non-operable, with brain injury	$ 35.00
epressed	75.00
mpound	150.00
ain tumors	150.00

AIN INJURIES—OPERABLE

xtradural hematoma	$150.00
ubdural hematoma	150.00
xploratory trephination	
One side	50.00
Two sides	75.00
tracortical clot	150.00
rterio-venous fistula, intracranial	150.00

INAL CORD

etion of anterior or posterior roots	$150.00
ecompressive laminectomy	150.00
emoval of or exploration for an extruded nucleus, pulposus or ruptured intervertebral disc	150.00

RIPHERAL NERVE

ture, decompression, or transplantation of single nerve	$ 25.00
Each additional	10.00
Maximum	100.00
neumonenchephalogram	25.00
entriculogram	35.00
pinal cord tumors	150.00
peration for pain associated with malignancy or similar untreatable disease requiring intraspinal nerve sections or cordotomy	150.00

ISCELLANEOUS

ection of sensory root for 5th nerve neuralgia	$150.00
ection of vestibular nerve for Meniere's disease or aural vertigo	150.00
peration for Scalenus anticus syndrome	50.00
raniotomy for brain abscess	150.00
raniotomy for conditions not listed herewith	150.00
ilateral orbital decompression	150.00
horoidectomy for hydrocephalus	150.00
xcision of meningocele	75.00
umbar puncture, with fracture or operative work, (diagnostic excluded)	5.00

YMPATHETIC SYSTEM

nilateral lumbar sympathectomy	$100.00
ilateral lumbar sympathectomy	150.00
esection of pre-sacral plexus	150.00
ilateral, thoraco lumbar sympathectomy	150.000

BSTETRICS

Pregnancy, delivery (Does not cover prenatal and postnatal home and office care.)	50.00
Miscarriage (curettage)	25.00
Caesarean section, vaginal	100.00
Caesarean section, abdominal	100.00
Pregnancy, ectopic	100.00

YNECOLOGY

Bartholin's gland, incision	$ 5.00
Bartholin's gland, excision	25.00
Labial tumors and cysts, removal	20.00
Atresia of vagina, plastic	50.00
Fistula, recto-vaginal	100.00
Fistula, vesico-vaginal	100.00
Cul-de-sac, drainage	35.00
Cauterization or conization of cervix	10.00
Dilatation with or without curettaoge or cauterization	25.00
Uterine polyp removal with dilatation and curettage	25.00
Cervical polyp removal	5.00
Trachelorrhaphy	35.00
Cervix amputation	50.00
Oophorectomy or resection of ovaries	100.00
Hysterectomy	150.00
Myomectomy	100.00
Uterine flexions, etc. correction, (plus surgery of tubes & ovaries)	100.00
Same with vaginal plastic repair	125.00
Salpingectomy	100.00
Salpingoophorectomy	100.00
Cystocele	50.00
Rectocele	50.00
Combined cystocele and rectocele	75.00
Prolapse operations (interposition, Manchester)	100.00
Vulvectomy	75.00
With groin dissection	150.00

OPHTHALMOLOGY

Foreign body removal, within anterior or posterior chamber	$100.00
Cornea, paracentesis	20.00
Conjunctival suture	15.00
Conjunctival flap for corneal ulcer, etc.	25.00
Chalazion, excision, single	10.00
Multiple	25.00
Lachrymal sac, removal	50.00
Entropion or ectropion, Ziegler's puncture	30.00
Entropion or ectropion, plastic operation	50.00
Entropion or ectropion, plastic operation grafts or flaps	75.00
Symblepharon, release	30.00
Pterygium	25.00
Corneal ulcer, cauterization	5.00
Corneal ulcer, deliminating keratotomy	25.00
Tarsorrhaphy, orbicularis paralysis	30.00
Ptosis, (single)	50.00
Strabismus, one or more muscles	75.00
Cataract, needling	40.00
Cataract, removal	100.00
Iridectomy	50.00
Glaucoma, filtration operation	100.00
Enucleation or evisceration	50.00
Same and implantation	75.00
Tumor, exenteration of orbit	100.00
Dacryocystorhinostomy	100.00
Detached retina	125.00

OTOLOGY

Aural polyp	$ 10.00
Paracentesis tympani	10.00
Mastoidectomy, acute single	100.00
Mastoidectomy, acute bilateral	125.00
Mastoidectomy, radical single	150.00
Fenestration for otosclerosis	150.00

NOSE AND THROAT

Nasal polyps, removal	$ 10.00
Antrum, Caldwell-Luc	50.00
Ethmoidectomy	35.00
Frontal sinus, radical	100.00
Turbinectomy	10.00
Submucous resection	50.00
Palatorrhaphy	100.00
Tonsillectomy and adenoidectomy	
Under 15	25.00
Over 15	35.00
Laryngectomy	150.00
Tracheotomy	50.00
Malignant disease, accessory sinuses (radical operation) One sinus	100.00
Multiple	150.00
Malignant disease, tonsil and pharynx (radical operation)	100.00
Antrum puncture and irrigation	5.00
Antrum window	50.00

ORTHOPEDIC

Spinal fusion	$150.00
Cartilage of condyle of femur, removal of	75.00
Bone plate, removal of	25.00
Talipes	50.00
Semilunar cartilage, removal from joint	75.00
Tenotomy, simple, open	25.00
Closed	15.00
Claw foot, except bone surgery—see foot stabilization	50.00
Coccyx, excision of	25.00
Arthrotomy, any major joint	75.00
Hallux valgus, single radical operation	50.00
Exostectomy	25.00
Osteomyelitis, sequestrum removal	25.00
Hallux valgus, bilateral radical operation for	75.00
Foot stabilization	150.00
Hammer toe, operation for	35.00
Arthrodesis of knee, hip, shoulder or elbow	150.00
Torticollis, operation for	75.00
Arthroplasty, any major joint	150.00
Hip joint, resection	150.00
Any other major joint, resection	100.00
Any joint, fingers or toes, resection	25.00

AMPUTATIONS

Shoulder, disarticulation	$125.00
Upper arm	50.00
Forearm	50.00
Hand	50.00
Finger, single	15.00
Each additional	10.00
Hip	125.00
Thigh	75.00
Knee	75.00
Leg	75.00
Toe	15.00
Each additional	10.00
Foot	50.00
Elbow	75.00
Scapulothoracic amputation	150.00

DISLOCATIONS—CLOSED

Carpal bone, one	25.00
Each additional	10.00
Clavicle	25.00
Elbow	25.00
Finger, one	5.00
Each additional	5.00
Hip	35.00
Knee	35.00
Mandible	10.00
Metacarpal bone, one	15.00
Each additional	5.00
Metatarsal bone, one	15.00
Each additional	5.00
Patella	15.00
Rib	10.00
Shoulder	25.00
Tarsal bone, one	25.00
Each additional	10.00
Thumb	10.00
Toe, one	5.00
Each additional	5.00
Vertebra, one or more	100.00

SIMPLE FRACTURES—CLOSED

Lower jaw	$ 25.00
Carpal bone, one	25.00
Each additional	10.00
Clavicle	25.00
Coccyx	10.00
Femur	75.00
Tibia or fibula or both	50.00
Potts' or Cotton's fracture	75.00
Finger, one	10.00
Each additional	5.00
Humerus	50.00
Metacarpal bone, one	15.00
Each additional	10.00
Metatarsal bone, one	15.00
Each additional	10.00
Patella, closed	25.00
Nasal bone or bones, reduction	25.00
Pelvis	75.00
Radius or ulna, or both	25.00
Rib, one or more	10.00
Sacrum	35.00
Scapula	25.00
Skull	35.00
Sternum	25.00
Tarsal bone, one (exclude os calcis and astragalus)	25.00
Each additional	10.00
Toe, one	10.00
Each additional	5.00
Vertebra, one or more	100.00
Os calcis or astragalus, or both	50.00

Similarly, the attached x-ray and laboratory schedule will govern (80 per cent of the scheduled fee as listed) until fee schedules covering these fields have been established by the State Medical Society.

Clinical Laboratory Examinations

CTERIOLOGICAL EXAMINATIONS

ıltural examination for fungi	$ 5.00
icroscopic examination for fungi	1.00
ıeumococcus typing	3.00
ıs or exudate (smear)	1.00
ıs or exudate, cultural examination, including classification of organism	5.00
. Pallidum (dark field)	2.00
hroat culture, including classification of organism	5.00
hroat smear	1.00

OOD

gglutination test for typhoid, paratyphoid, dysentery, or undulant fever	2.00
eeding time	1.00
ood calcium	3.00
ood chlorides	3.00
ood culture, including classification of organism in positive culture	5.00
ood platelet count	1.50
ood smear for malaria	2.00
ood typing (grouping)	2.00
arbon dioxide combining power of blood plasma (Van Slyke)	3.00
hemical examniation of blood, complete, including creatinin, dextrose, urea nitrogen (or non-protein N) and uric acid	*15.00
holesterol	3.00
oagulation time	1.00
omplement fixation test for gonococcus infection	4.00
omplement fixation test for syphilis (Wasserman)	3.00
omplement fixation test for tuberculosis	4.00
reatinin	3.00
extrose	3.00
otal erythrocyte count	1.50
ragility test for erythrocytes	3.00
Iemoglobin estimation	1.00
Iydrogen ion concentration	3.00
)ifferential leucocyte count	1.50
otal leucocyte count	1.50
omplete blood count, including total erythrocyte count, hemoglobin estimation, differential leucocyte count and total leucocyte count	3.00
Non-protein nitrogen	3.00
)ccult blood	1.00
Blood phosphorous	2.00
Precipitation test for syphilis (Kahn)	2.00
Reticulocyte count	2.00
Sedimentation rate	2.00
Estimation of sugar tolerance	5.00
Urea nitrogen	3.00
Uric acid	3.00
Van den Borgh blood test for icterus	2.00
Volume index	2.00

ECES

ultural examination of feces for causative micro-organism (including classification of bacterium)	5.00
Fat in feces	1.00
Parasites and ova	2.00

PATHOLOGICAL EXAMINATIONS

Autopsy, complete, with report (including histological examinations)	$ 35.00
Tissue examination, with report	5.00

SKIN TESTS

Allergy investigation (protein sensitization tests) including complete examination and report: For each 25 tests (This fee will include history, examination and diagnosis. For treatment there is a fee of $3.00 per office visit)	$ 25.00
Tuberculin	2.00

SPINAL FLUID

Examination of spinal fluid for causative organism (smear)	$ 2.00
Cell count	1.50
Colloidal gold reaction	3.00
Complement fixation test for syphilis (Wasserman)	3.00
Cultural examination of spinal fluid, including classification of causative microorganism	5.00
Globulin test	1.00
Complete examination of spinal fluid, including complement fixation test, colloidal gold reaction, globulin test, and cell count	7.50
Precipitation test for syphilis (Kahn)	3.00

SPUTUM

Tubercle bacillus (plain smear)	$ 3.00
Tubercle bacillus (concentration method)	3.00

STOMACH CONTENTS

Examination of duodenal content for pancreatic ferments	$ 5.00
Examination of gastric content for acidity, by histamine	3.00
Examination of gastric content for pepsin	3.00
Routine, chemical (including test meal and withdrawal of stomach content)	5.00

URINE

Chemical examination, routine	$ 1.00
Chemical and microscopical examination	2.00
Chrorides	3.00
Creatinin	3.00
Cultural examination, including classification of microorganism	3.00
Hydrogen ion concentration	3.00
Mosenthal test	3.00
Total nitrogen	3.00
Renal function test (including phenolsulphonephthalein)	3.00
Tubercle bacilli	2.00
Urea nitrogen	3.00
Uric acid	3.00
Urobilin	1.00

MISCELLANEOUS EXAMINATIONS

Animal inoculation for diagnosis, with report of autopsy	$ 5.00

*A tentative fee

Preparation of autogenous vaccine	5.00
Determination of basal metabolic rate	5.00

X-RAY WITH INTERPRETATION

Abdomen, flat plate	$ 7.50
Ankle joint, anteroposterior and lateral views	5.00
Arm, humerus, anteroposterior and lateral views	5.00
Bladder, with injection, anteroposterior view	10.00
Chest, for pulmonary, cardiac or rib fracture diagnosis, plain	10.00
Chest, for pulmonary, cardiac or rib fracture diagnosis, stereoscopic	15.00
Clavicle, anteroposterior view	5.00
Elbow, anteroposterior and lateral views	5.00
Fluoroscopy, when required, without film	5.00
Foot, anteroposterior and lateral views	5.00
Forearm, radius and ulna, anteroposterior and lateral views	5.00
Foreign body in eye, location of (the fragment charted in three planes and its dimensions ascertained by the method of Sweet or equivalent)	25.00
Gall bladder, Graham technic, including cost of dye	15.00
Gastrointestinal tract, including barium meal, complete X-ray study including fluoroscopy	35.00
Hand, anteroposterior and lateral views	5.00
Hip joint, anteroposterior view, plain	7.50
Hip joint, anteroposterior view, stereoscopic	10.00
Intestine, barium clysma, 14 by 17 films for position and outline	10.00
Jaw, upper and lower	5.00
Kidneys, right and left for comparison	7.50
Knee joint, anteroposterior and lateral views	5.00
Leg, tibia and fibula, anteroposterior and lateral views	5.00
Lipiodol injection for bronchiectasis, etc., including roentgenograms	20.00
Pelvis, anteroposterior view, plain	7.50
Pelvis, anteroposterior view stereoscopic	10.00
Pyelography, using uroselectan or similar preparation (including cost of drug)	15.00
Pyelography, retrograde	25.00
Scapula	5.00
Shoulder joint, anteroposterior view, plain	5.00
Shoulder joint, anteroposterior view, stereoscopic	10.00
Sinuses, frontal and ethmoid, anteroposterior and lateral views	10.00
Sinuses, mastoid, right and left sides for comparison	10.00
Sinuses, maxillary, anteroposterior and lateral views	10.00
Sinuses, frontal, ethmoid and maxillary, anteroposterior and lateral views	15.00
Skull, anteroposterior and lateral views, plain	10.00
Skull, anteroposterior and lateral views, stereoscopic	15.00
Spine, cervical, anteroposterior and lateral views	7.50
Spine, dorsal, anteroposterior and lateral views	10.00
Spine, lumbosacral, with coccyx, anteroposterior and lateral views	10.00
Spine, entire	22.50
Stomach, barium or bismuth meal, 14 by 17 film; after ingestion, four 8 by 10 films for detection of duodenal cap; total of five films, including fluoroscopy	20.00
Teeth, single (up to and including 7 films) each	1.00
Teeth, series (7 films to and including full mouth) series	7.0
Thigh, femur, anteroposterior and lateral views	7.5
Wrist, anteroposterior and lateral views	5.0

INTERPRETATION OF ROENTGENOGRAMS

Bones and joints, plain anteroposterior and lateral views	$ 3.0
Chest for pulmonary diagnosis, plain or stereoscopic	3.0
Gastrointestinal series	3.0
Genitourinary tract	3.0
Kidney, films	3.0
Skull, following ventriculography or encephalography	3.0

X-RAY AND RADIUM THERAPY

Radium therapy, per milligram hour (Minimum fee $5.00; maximum expenditure allowed not to exceed $100.00; where additional treatments are necessary, special authority must be obtained from Central Office)	$ 0.0
X-ray therapy, per treatment (Maximum expenditure allowed not to exceed $100.00; where additional treatments are necessary, special authority must be obtained from Central Office)	10.00-25.0
X-ray therapy, superficial	5.00

Rupture of and Inversion of Uterus

A group of investigators at the Medical School of the University of Witwatersrand, Johannesburg, South Africa, has published some interesting observations on rupture of the uterus. They found by a review of the literature that condition is a rare complication of pregnancy in Western countries, the average incidence being 1 in 1,707 taken over 920,149 deliveries. Outside of the common cause of mismanagement of labor, there remained a variable number of cases where the cause of rupture was unexplained. Experimental work was carried out on rats, fed on a diet below the nutritional optimum. 24 per cent developed uterine rupture. From these experiments the conclusion is reached that in some women rupture of uterus may be the result of nutritional factors which modify the behavior of the uterine musculature and the associated connective tissue during pregnancy, irrespective of trauma or disproportion.

Another group at the same school obtained by similar experiments inversion of the uterus in 25 per cent. This group suggests that nutritional factors may interfere with the mechanisms which normally coordinate uterine contraction after normal parturition.

Children's Bureau Advisory Committee Formed

Forty spokesmen for the producers and consumers of health services for mothers and children met in Washington, D. C., in September, to form an advisory committee to the U. S. Children's Bureau on Federal-State programs for maternal and child health and crippled children's services. The Children's Bureau is a unit in the Social Security Administration, Federal Security Agency.

Invited by the Children's Bureau to advise it on matters of public policy affecting the promotion of better health for mothers and children, this new committee is the first in the child health field, with representation both of non professional and professional groups, to be given this broad mandate. Dr. Harry H. Gordon, professor of pediatrics, University of Colorado Medical Center, was elected chairman of the Committee for three years.

Members include (1) officially designated representatives of medical, nursing, hospital, dental, medical social work, physiotherapy, and dietetic associations; (2) representatives of voluntary health agencies; (3) leaders in labor, farm, women's and veterans groups; (4) specialists from graduate schools in medicine and allied sciences; and other distinguished citizens.

While devoting much of its time at this first organizing meeting to becoming acquainted with the Children's Bureau work in the fields of maternal and child health and crippled children services, the Committee discussed several policy matters. Pointing to the tremendous shortage of all kinds of professional personnel in child health, the Committee discussed at length the ways and means of stimulating the training of more professional workers and auxiliary personnel for the maternal and child health programs and reviewed the way the State health agencies are now working with universities to this end. The Children's Bureau reported that the existing limitations on the total available funds limits the amount of work that can be undertaken to expand professional education opportunities.

Closer teamwork and understanding between non governmental and governmental agencies working to improve child health, the Committee stressed, should be developed. To this end, the Children's Bureau was encouraged to set up an information exchange on programs and projects of such agencies as a first step toward better over-all planning by voluntary groups and government in behalf of children and mothers.

Better care for more children, particularly for those of school age and for those with seriously crippling conditions, was accepted as a goal by the Committee without arriving at any specific recommendations.

The Children's Bureau is responsible for administering the $18,500,000 grants which the Congress makes available each year to the States to "extend and improve" their maternal and child health services and services to crippled children. Under these State maternal and child health programs, many kinds of services operate for the promotion of health and a more limited range of services for the treatment of sick mothers and children. State programs for crippled children attempt, within their resources, to provide for diagnosis and treatment as needed.

The fact that the Social Security Act Title V puts a ceiling on the amounts of Federal funds available for appropriation for these programs and that appropriations are now made up to this limit, was recognized as a deterrent to expansion of the programs. No decision was taken at this first meeting as to how this limitation should be overcome though a number of ways were discussed.

In welcoming the members of the new Advisory Committee at their first meeting, Dr. Martha M. Eliot, associate chief of the Children's Bureau, emphasized the wide opportunities of the group to help in moulding public policies in respect to the development of these programs.

"The Congress has laid down broad rules within which Federal aid can be given. Within that area, the Children's Bureau must make many policy decisions as to which services are most needed; how they can be provided effectively; what help health workers and agencies need in providing services. On such questions as these," Dr. Eliot said, "we want the benefit of your counsel as to what is in the best interest of mothers and children. The door is wide open to you, as spokesmen for the purveyors and consumers of health services, to tell us what we ought to do and how we ought to move—always within the authority given us by the Congress."

The Committee recommended meetings be called by the Children's Bureau at least twice a year.

James R. Miller, M.D., of Hartford, Trustee of AMA, represents the AMA on the Advisory Committee of the Children's Bureau.

Directory of Washington Committees and Boards

Reprinted from Washington Report on Medical Sciences

NATIONAL SECURITY RESOURCES BOARD (DIVISION OF MEDICAL SERVICES)

Chief: Dr. James A. Crabtree. *Section heads:* Dr. Thomas C. Anderson, manpower; Vincent B. Lamoureux, environmental sanitation; Lieut. Col. Howard B. Nelson, health supplies; Ruth Freeman, R. N., nursing. (Note: Head of hospital and physical facilities section yet to be designated.) *Function:* Determination of existing and potential resources in medical and related manpower, health supplies, health facilities, sanitary engineering and nursing. Advisor on formulation of Selective Service deferment policies. *Mail address:* Old State Building, 17th Street and Pennsylvania Avenue, N. W., Room 322. *Telephone:* STerling 4700, Extension 3446.

COMMITTEE ON MEDICAL AND HOSPITAL SERVICES, ARMED FORCES ("HAWLEY BOARD")

Chairman: Dr. Paul R. Hawley. *Members:* Maj. Gen. Raymond W. Bliss, Surgeon General, U. S. Army; Rear Adm. Clifford A. Swanson, Surgeon General, U. S. Navy; Maj. Gen. Malcolm C. Grow, Air Surgeon, U. S. Air Force. *Executive Secretary:* Rear Adm. Joel T. Boone, (MC) U. S. Navy. *Function:* An ad hoc committee responsible to the Secretary of Defense, the Hawley Board is directed to investigate and make recommendations on improvement of military medical, hospitalization, supply and other services. Joint staffing of hospitals, consolidation of hospitals in certain areas and unified procurement of materiel are included in this study. The Board has 21 working subcommittees on dental matters, physical and mental standards, medical forms, research, budgets, nomenclature, education, etc. *Mail address:* The Pentagon, Room 3D683. *Telephone:* REpublic 6700, EXtension 5930.

COMMISSION ON ORGANIZATION OF EXECUTIVE BRANCH OF GOVERNMENT (MEDICAL SERVICES COMMITTEE)

Chairman: Tracy S. Voorhees (Assistant Secretary of the Army). *Members:* Drs. Joel T. Boone, Frank R. Bradley, Robin C. Buerki, Edward D. Churchill, Michael E. DeBakey, Paul R. Hawley, Hugh R. Leavell, William C. Menninger, Hugh J. Morgan, O. H. Perry Pepper, Alfred N. Richards, Allen O. Whipple and Ray Lyman Wilbur, also Goldthwaite H. Door, Henry Isham and Charles Rowley. *Executive Secretary:* Howard M. Kline. *Function:* To study medical and public health activities of the Federal government, including those of Public Health Service, Veterans Administration, Army and Navy, and make appropriate recommendations for eliminations of duplication, greater economy and other improvements to the Commission, whose head is Herbert Hoover. The Commission's report on the entire executive branch will be delivered to Congress in January. *Mail address:* Normandy Building, 1626 K Street, N. W., Room 803. *Telephone:* EXecutive 4160, Extension 2750.

HEALTH EMERGENCY PLANNING UNIT

Director: Dr. Norvin C. Kiefer, Senior Surgeon, U. S. Public Health Service, assisted by Gordon E. McCallum, senior sanitary engineer. *Function:* To cooperate with the various states and other Federal agencies, as well as professional and voluntary organizations, on planning of measures for safeguarding public health in event of emergency. *Mail address:* Federal Security Building, Room 5070. *Telephone:* EXecutive 6300, #2846.

OFFICE OF CIVIL DEFENSE PLANNING (MEDICAL SECTION) (RADIOLOGICAL SAFETY SECTION)

Technical advisors: Drs. Norvin C. Kiefer and Perrin H. Long (consultant), Medical Section; Drs. Richard Gerstell and Arthur Lyon (consultant), Radiological Safety Section. *Function:* Development and coordination of plans for training and most efficient utilization of medical manpower and protection of civil population in event of attack or invasion. OCDP, which is responsible to Secretary of Defense, probably will release its over-all defense report in October. *Mail address:* The Pentagon, Room 3B660. *Telephone:* REpublic 6700, Extension 75124.

RESEARCH AND DEVELOPMENT BOARD (COMMITTEE ON MEDICAL SCIENCE)

Chairman: Dr. Francis G. Blake (Yale). *Executive Director:* Dr. Joseph F. Sadusk, Jr. *Function:* "Survey, analysis and evaluation of all aspects of research and development activities in the field of medicine and allied sciences, both within and without the Military Establishment, for the purpose of formulating an adequate and efficient and integrated program of research and development in the field of medical science as applied to the needs of the departments of the National Military Establishment." *Mail address:* The Pentagon, Room 3C560. *Telephone:* REpublic 6700, Extension 73534.

OFFICE OF NAVAL RESEARCH (MEDICAL SCIENCES DIVISION)

Director: Capt. C. W. Shilling (MC) U. S. Navy. *Section heads:* Dr. Orr E. Reynolds, physiology; William Consolazio, biochemistry; Dr. Roger Reid, microbiology; Dr. Henry A. Imus, psychophysiology; Dr. J. W. Macmillan, psychology; Dr. M. C. Shelesnyak, human ecology; Dr. Sidney Galler, biophysics; Comdr. C. A. Schlack (DC) U. S. Navy, dental. *Function:* Planning and supervision of research contracts with medical schools, universities and other institutions conducting studies in the medical and allied sciences. ONR, including its medical division, is actually an "old line" Federal unit, in contrast with the agencies listed up to this point, but it is placed in this directory because of its close relationship with civilian medical institutions throughout the country. *Mail address:* Navy department. *Telephone:* REpublic 7400, Extension 5910.

ATOMIC ENERGY COMMISSION (DIVISION OF BIOLOGY AND MEDICINE)

Director: Dr. Shields Warren. *Function:* Safety of employes in National Laboratories operated by AEC, promotion of research, sponsorship of fellowships in pre- and post-doctoral biological, medical and physical sciences. Like ONR and the agencies listed below, AEC and its biology-medicine division are permanent Federal bodies whose conception and operation do not belong in any special or tem-

porary mission category. *Mail address:* 19th Street and Constitution Avenue, N. W. *Telephone:* STerling 8000.

AN AMERICAN SANITARY BUREAU

Director: Dr. Fred L. Soper. *Function:* Service to the 20 Latin American Republics in matters relating to public health. Operations have been markedly expanded since Dr. Soper's accession to the directorship last year and several new sections, including nursing and supply, have been established in recent months. (Quasi-governmental.) *Mail address:* 2001 Connecticut Avenue, N. W. *Telephone:* NAtional 6635.

National Blood Program (American Red Cross), Dr. Ross T. McIntire, director; 18th and E Streets, N. W., telephone REpublic 8300.

National Research Council, Division of Medical Sciences, Dr. Lewis R. Weed, director; 2101 Constitution Avenue, N. W., telephone EXecutive 8100.

Health Liaison Office, Department of State, Dr. L. L. Williams, director; 21st and C Streets, N. W. (Old Potomac Park Apts.), telephone REpublic 5600.

Medical Office, Selective Service, Col. Richard H. Eanes, director; 1712 G Street., N. W., telephone REpublic 5500.

National Institutes of Health, Dr. R. E. Dyer, director; Bethesda 14, Md., telephone OLiver 1400.

National Cancer Institute, Dr. J. R. Heller, Jr., director; Bethesda 14, Md., telephone OLiver 1400.

National Heart Institute, Dr. C. J. VanSlyke, director; Bethesda 14, Md., telephone OLiver 1400.

AMA Council on National Emergency Medical Service Issues Information Bulletin

To keep the State Medical Society Secretaries and Committees on National Emergency Medical Service informed on latest developments in this important field, Dr. Harold R. Hennessy, secretary of new AMA Council, is publishing an *Information Bulletin.* In the first issue of the *Bulletin* is explained the object of the Council on National Emergency Medical Service, viz, "the task of coordinating the efforts of the American Medical Association relative to the mobilization of our nation's Armed Forces, industry, agriculture and civilian population in time of national emergency."

The personnel of the original Committee on Military Service is listed, also the names of the standing committee known as the Council on National Emergency Medical Service. Further information included in this first *Bulletin* covers the accomplishments of the Council to date, the plan developed by the Council on Industrial Health, and the appointment of the medical advisory committee of the National Security Resources Board. The *Bulletin* is completed with a roster or the state and territorial chairmen of the committees on National Emergency Medical Service.

Further numbers of the *Bulletin* are planned.

The Medical Student Must Be Taught

General Practice News, published by the American Academy of General Practice, tells us that the medical student must be taught (1) the importance of the general practitioner in the present day medical setup; (2) an equal amount of psychology as compared to technology; (3) that confidence is begotten of integrity—just plain honesty; (4) by the general practitioner; and (5) that the general practitioner is not just a general practitioner because of his ignorance, laziness, lack of training or some other form of deficiency, but that in the majority of instances he is a G.P. because of choice.

Washington Chest Survey

Dr. Arthur C. Christie, of Washington, D. C., told the American Roentgen Ray Society at its recent convention in Chicago that more than 5,000 cases of unsuspected tuberculosis were found in the mass tuberculosis chest survey which was carried out in the nation's capital from January 12 to July 1, 1948.

"A significant fact disclosed by the Washington survey," he said in a paper delivered before the Society, "is the relation of the total number of cases of tuberculosis disclosed by the survey to the cases registered at the Washington Health Department as tuberculosis. Of the more than 6,000 cases, only 567 were on the tuberculosis registry, leaving about 5,600 cases previously unknown to the Health Department, of which number 83 per cent to 85 per cent are in a minimal stage and about 10 per cent only moderately advanced."

Dr. Christie said that a total of 503,398 persons were examined in the survey, but that a complete analysis of the results will not be avaliable for several months. He added that his statistics were subject to future revision.

Dr. Christie urged physicians, general practitioners and specialists alike to take a more active community interest in establishing adequate hospital and public health department facilities and personnel for the care of tuberculous patients.

THE USE OF STREPTOMYCIN IN TUBERCULOSIS

A Report by the Committee on Chemotherapy and Antibiotics of the American Colleg of Chest Physicians — September 23, 1948

The Committee on Chemotherapy and Antibiotics of the American College of Chest Physicians submits the following report of the use of streptomycin in tuberculosis.

INDICATIONS FOR TREATMENT

Nearly all forms of tuberculosis respond to treatment with streptomycin in some degree. However, the drug should by no means be used indiscriminately.

Pulmonary tuberculosis. It is extremely difficult to lay down hard and fast rules for the use of streptomycin in pulmonary tuberculosis. Especial care in the selection of cases is necessary. The drug has its greatest usefulness in cases with an appreciable amount of exudative disease. In some other cases streptomycin is responsible for symptomatic improvement and the prevention of complications.

1. Definitive treatment: This category includes chiefly progressive lesions of recent origin with little or no destruction of tissue, such as progressive primary tuberculosis and tuberculosis due to hematogenic and bronchiogenic dissemination.

2. Preparation for surgical procedures, including temporary and permanent collapse and excisional surgery. In some cases pneumothorax can be instituted sooner and with greater safety after a course of streptomycin. Not infrequently the drug is of great value in preparing patients as candidates for thoracoplasty. As prophylaxis, streptomycin should be used routinely in excisional procedures.

It must be emphasized again and again that streptomycin is *not* a substitute for sanatorium care and other proven procedures. Rather it is a valuable adjunct to these other measures.

Extrapulmonary tuberculosis. Streptomycin is the only treatment available in miliary tuberculosis and tuberculous meningitis. In such cases early and intensive treatment is imperative. Streptomycin is the treatment of choice for tuberculous sinuses, tuberculosis of the oropharynx, larynx and tracheobronchial tree, tuberculous enteritis and peritonitis, tuberculous otitis media, and tuberculous pericarditis. In renal tuberculosis, symptomatic improvement is usually prolonged and bacterial conversion occurs in some cases. Tuberculosis of the bones and joints is often improved by streptomycin but chemother apy is not a substitute for orthopedic surgery whe this is indicated.

Streptomycin is valuable as preoperative and post operative treatment of tuberculosis in surgery of th genito-urinary tract, surgery of bones and joints pericardiolysis, incision and drainage of abscesse and fistulectomy.

ADMINISTRATION

Streptomycin is administered by intramuscular o deep subcutaneous injection. The optimal regime for the administration of streptomycin has not bee determined. In most forms of tuberculosis result appear to be satisfactory when a dose of 0.5 to gram a day are administered in 1 or 2 injections fo 6 to 8 weeks. With this mode of therapy complications are very infrequent and in most cases thei clinical importance may be discounted. In tuberculous meningitis and miliary tuberculosis treatmen should be vigorous; a dose as high as 2 grams pe day for 4 months, or longer if necessary. In tuberculous meningitis results seemingly are better when intramuscular injection is supplemented by intrathecal injection of from 25 to 50 milligrams every 24 to 48 hours for 2 or 3 months, or as long as this method of administration is tolerated by the patient.

Since drug fastness is apparently closely related to duration of treatment, regardless of the daily dosage, limitation of the period to a few weeks may be effective in avoiding this phenomenon in many cases.

The physician handling a case of tuberculosis would do well to ask himself the following questions before administering streptomycin.

1. Why is streptomycin being used: for definitive therapy, as preparation for surgery, for prophylaxis, or for relief of distressing symptoms?

2. Is the type of lesion present of such a nature as to warrant the use of streptomycin in addition to other available therapy?

3. Can the purpose of chemotherapy be accomplished within the relatively short period of the drug's effectiveness? (Almost three-fourths of the patients show resistant organisms after 3 to 4 months of continuous daily streptomycin treatment.)

OTHER CHEMICAL AND ANTIBIOTIC SUBSTANCES

There is no other substance known today which compares with streptomycin in its effectiveness against tuberculosis. The sulfones, promin and promizole, are generally ineffective alone. Experimental work is in process to determine whether or not there is synergistic action when any of these are added to streptomycin. Para-aminosalicylic acid is promising on the basis of laboratory experimentation but sufficient clinical work has not yet been done to permit evaluation of this drug. Subtilin has not had sufficient clinical trial and there is not yet enough animal experimentation to indicate its usefulness. Of the many other antibiotic substances, none has shown in preliminary experimentation indication of real value against tuberculosis and none has had clinical trial.

THE CARE OF HAND INJURIES
II
Requirements of Early Definitive Treatment

I. The first aid treatment of hand injuries is directed fundamentally at protection. It should provide protection from infection, from added injury, and from future disability and deformity. This protection is afforded by non interference with the wound, cleanliness of surrounding areas, the application of sterile protective dressings and immobilization in the position of function.

II. The general requirements for proper early definitive care are:

a. Thorough evaluation of the injury.

1. Determination of the time, place, causative agent and mechanism of the injury.

2. Determination of the nature and extent of the first treatment given.

3. Determination of infection status; whether the wound is relatively clean, grossly contaminated or with infection established.

4. General nature of the wound: i.e., contusion, abrasion, burn, incised wound, lacerated wound, crushing wound, puncture wound, tooth wound, imbedded foreign body, fracture, compound fracture, amputation or combined injuries.

5. Evaluation of structural damage.

(a) Degree and extent of surface injury.

(b) Source of major bleeding.

(c) Evidence of tendon or muscle damage by testing function *against resistance.*

(d) Evidence of nerve injury elicited by testing for motor and *sensory* functions.

(e) Bone and joint injury determined by x-ray.

(f) Discovery and exact localization by x-ray of suspected opaque foreign bodies.

b. Adequate facilities and equipment.

1. Each hospital or clinic should have at least one surgeon who is thoroughly familiar with the anatomy and physiology of the hand and who is prepared to undertake the early treatment of its major injuries.

2. Such treatment should be rendered under strictly aseptic conditions, preferably in an operating room, with careful adherence to aseptic technic in the matter of scrubbing, draping, masking and the use of gloves.

3. An adequate supply of appropriate instruments.

4. Sufficient assistance to assure good exposure.

5. Good lighting.

6. Provision of a bloodless field by means of pneumatic tourniquet or blood pressure cuff.

7. Complete anesthesia for the patient, preferably by general anesthetic.

c. Application of appropriate treatment.

1. Thorough cleansing of a wide area around the wound with the wound protected. (Entire hand and forearm.) Shaving, soap and water scrub.

2. Thorough cleansing of the immediate wound area, preferably with soap and water or a bland detergent. Antiseptics should not be used in or on the wound.

3. Careful inspection of the wound and assurance of adequate exposure, by additional incision if necessary, *closely paralleling natural creases.*

Prepared by the American Society for Surgery of the Hand—October, 1948
Released by Committee on Fractures and Other Traumas of American College of Surgeons

4. Thorough toilet of the wound, removing, under inspection, all foreign matter. Excision, by sharp and careful dissection, of all completely devitalized or grossly soiled tissue in the wound surfaces. It is essentially that the greatest care be exercised to spare all tissues that may be viable, particularly skin, tendon, nerve and bone fragments.

5. Assurance of hemostasis by ligation of major injured vessels.

6. Repair of injured nerves by end-to-end union with fine interrupted perineural sutures. The uniting of divided digital nerves is important to future function.

7. Repair of other soft tissue injuries, where appropriate: i.e., in clean wounds of short duration, in well cleaned contaminated wounds of not over eight hours' duration, never in wounds with established infection.

8. Reduction of fractures and dislocations, and retention in corrected position by traction or splinting in the position of function (position of grasp with wrist in dorsiflexion).

9. Application of protective dressing, fingers separated by gauze and hand immobilized to such extent as may be necessary to permit healing, in the position of function (never in the flat position).

10. Administration of antibiotics and protective antitoxin as indicated.

d. After-treatment.

1. Elevation and rest of the hand.

2. Non interference with initial dressing for a sufficient time to permit healing, unless evidences of suppuration develop.

3. Restoration of skin coverage of denuded areas at earliest possible time. Partial thickness skin grafting is a simple and valuable means of promoting early healing.

4. Early restoration of function for non affected parts of the hand by directed *active* motion to the fullest extent that will not jeopardize healing of repaired structures.

5. Restoration of function in affected parts of the hand by directed *active* motion as early as is consistent with full healing and preservation of the repair of damaged structures.

Subsequent articles will deal with the particular treatment of special types of injuries.

THE DOCTOR'S OFFICE

Gunar N. Bohan, M.D., announces the opening of an office for the general practice of medicine and surgery at 31 Broadway, North Haven.

Francis L. DePasquale, M.D., announces the reopening of an office for the practice of medicine at 1992 Broad Street, Hartford.

Asa J. Dion, M.D., announces the reopening of his office for the practice of obstetrics and gynecology at 207 Washington Street, Hartford.

Larry Edwards, M.D., announces the opening of an office for the general practice of medicine and surgery at 968 East Main Street, Bridgeport.

Jack Gurwitz, M.D., announces the opening of an office for the practice of general surgery at 179 Allyn Street, Hartford.

Sydney Luria, M.D., announces the opening of an office at 881 Lafayette Street, Bridgeport.

Leonard Maidman, M.D., announces the removal of his office to Crossways, Wilton.

Frederick P. McIntyre, M.D., announces the opening of an office for the practice of internal medicine at 65 South Street, Stamford.

John C. Olsavsky, M.D., announces the opening of an office at 1395 Boston Avenue, Bridgeport.

Paul S. Pizzo, M.D., announces the opening of an office for the general practice of medicine at 247 South Street, Hartford.

Robert D. Russo, M.D., announces the opening of an office for the practice of radiology at 10 Washington Avenue, Bridgeport.

Philip E. Schwartz, M.D., announces the opening of an office for the practice of dermatology at 33 Pleasant Street, Middletown.

Stanley J. Weigle, M.D., announces the opening of an office for the general practice of medicine and surgery at 53½ Broad Street, Danielson.

Morris B. Whitman, M.D., announces that he has succeeded the late Max Climan, M.D., in the practice of radiology at 242 Trumbull Street, Hartford.

Herbert Wyatt, M.D., announces the opening of an office for the practice of internal medicine at 3 Colony Street, Meriden.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*

Egbert M. Andrews, Hartford
Joseph J. Bruno, New Haven
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Increased Compensation Payments

Veterans with disability rating of 60 per cent or more who have dependents have been advised by Veterans Administration to submit promptly to VA documentary evidence of dependency so that they may qualify for increased compensation payments under Public Law 877 of the 80th Congress.

The new law provides additional allowances for such disabled veterans who have a wife, children or dependent parents. The married veteran may receive up to $21 extra, with added amounts for additional dependents.

Veterans whose dependents are recorded in their VA claim folders as of September 1, 1948 will have until December 1 to file the evidence. These awards will be retroactive to September 1, the effective date of the law, otherwise the effective date of the increase will be the date of receipt of the evidence.

As to the veteran's wife and children, certified copies of public or church records usually are the best and most easily obtained evidence. If for any reason the veteran cannot get these, he should submit the best evidence available, such as sworn statements of responsible persons. For parents, proof of dependency in the form of sworn statements as to income and property ownership are required.

Veterans may obtain assistance in connection with the filing of their claims at any VA office, or from service organizations and state agencies.

Veterans Cured of Malaria

Thousands of veterans who contracted malaria overseas during World War II have been cured, Veterans Administration has announced. Within the next few years, the problem of relapse from war acquired malaria will be an insignificant one.

The rate of cures is indicated by VA statistics. During June 1947 approximately 500,000 veterans were receiving compensation for malaria incurred in service. Nine months later, in March 1948, this number had dropped to 32,000. It is still declining.

The number of relapses also has declined—from approximately 500,000 cases infected during the war to less than 10,000 at present.

The parasite eventually "burns itself out" in human bodies in from one to three years, although some cases are known to have remained infected for as long as 20 years.

Use of the drugs chloroquine, pamaquine (plasmochin), and the more recently synthesized 8-amino quinolines, such as pentaquine and isopentaquine, have given splendid results.

List of Participating Pharmacists in Home Town Service Plan

A veteran *should not* be referred to a participating pharmacy for the compounding of a prescription at Veterans Administration expense unless his prescription is dated during a period that the physician has been authorized to treat the veteran and that the prescription is written for the service connected disability which he has been authorized to treat.

ANSONIA

Robert L. Blume, 3 Maple Street

BALTIC

Baltic Pharmacy, R. R. Avenue

BRIDGEPORT

Ace Pharmacy, 602 East Main Street
Achorn's Pharmacy, 11 East State Street
Clinton Pharmacy, 1196 State Street
Cyrus Pharmacy, 420 Fairfield Avenue
Doctor's Pharmacy, 881 Lafayette Street
The Ethical Pharmacy, 1260 Main Street
Freeman Pharmacy, 1739 East Main Street
Gabriel's Drug Store, 1034 East Main Street
Gerstl's Pharmacy, 1367 Boston Avenue
Greenspun's Pharmacy, 1557 Fairfield Avenue
Kasin's Pharmacy Center, 2071 Main Street
Riccio's Medical Pharmacy, 942 East Main Street
Stivers North End Pharmacy, 3945 Main Street

BRISTOL

Boulevard Pharmacy, 98 Main Street

CANAAN

Kauttu's Pharmacy, Main Street
Service Pharmacy, Canaan

DANBURY

Kinner's Drug Store, 173 Main Street

DARIEN

Bell Pharmacy, 1 Tokeneke Road

DERBY

Blume's Pharmacy, 58 Elizabeth Street
Lee Drug Co., 249 Main Street

EAST HAMPTON

Hitchcock Pharmacy, 78 Main Street

ELMWOOD

Cole Pharmacy, 1119 New Britain Avenue

ESSEX

Hyde Drug Co., Inc., Main and Pratt Streets

FAIRFIELD

Grasmere Pharmacy, 80 Post Road

GLENBROOK

Glenbrook Pharmacy, 324 Hope Street

GREENWICH

Grannick's Drug Store, 271 Greenwich Avenue

GROTON

Thames Pharmacy, 2 Eastern Point Road

GUILFORD

Douden's Drug Store, 57 Whitfield Street

HAMDEN

Centerville Drug Shop, 2361 Whitney Avenue
Cherry Hill Drug Store, 1830 Dixwell Avenue
Hamden Pharmacy, 3350 Dixwell Avenue
Highwood Pharmacy, Dixwell Playhouse Bld.
Strand Pharmacy, 1219 Dixwell Avenue

HARTFORD

Arthur Drug Stores, 202 Farmington Avenue
Colt's Park Pharmacy, 315 Wethersfield Avenue
Euclid Pharmacy, 677-679 Blue Hills Avenue
Ideal Drug Co., Wethersfield Avenue
Malley Drug Co., 131 Main Street
Palmer and Duzak, 364 Asylum Street
Parent-Rexall Drug Co., 569 Park Street
Ray's Pharmacy, Garden Street
D. G. Stoughton Co., 255 South Whitney Street
Washington Pharmacy, 159 Washington Street
Zito's Pharmacy, 729 Wethersfield Avenue

EAST HARTFORD

East Hartford Drug Co., 943 Main Street
Elm Pharmacy, 39 Burnside Avenue

WEST HARTFORD

Kottenhoff's Drug Store, 979 B. Farmington Avenue

MANCHESTER

Arthur Drug Stores, Manchester
Quinn's Pharmacy, Inc., 873 Main Street
Weldon Drug Co., Inc., 901 Main Street

MERIDEN

Broderick and Curtin, 42 East Main Street
Lynch Drug Co., Inc., 298 East Main Street
Pigeion's Pharmacy, 445 Colony Street

MIDDLETOWN

Murphy's Drug Store, 644 Main Street

NAUGATUCK

Donovan's Pharmacy, 217 Church Street
Olson Drug Store, 174 Church Street
Raphael E. Ford, 2 Church Street

NEW BRITAIN

City Drug Store, Inc., 487 Main Street
Davis Drug Store, 1 Main Street
Park Street Pharmacy, 223 Park Street
Stanley Pharmacy, 720 Stanley Street
Zackin Pharmacy, Inc., 42 West Main Street

NEW HAVEN

Alden Pharmacy, 243 Alden Avenue
Apothecaries Hall, 90 Elm Street
Beck's Pharmacy, 543 Howard Avenue
D'Andrea's Pharmacy, 991 Whalley Avenue
Deegan-Hope Drug Store, 506 State Street
East Rock-Cedar Hill Pharmacy, 1320 State Street
El Dorado Pharmacy, 1147 Chapel Street
Eudowe Pharmacy, 1177 Chapel Street
Goldberg Pharmacy, Inc., 183 Oak Street
Grand Pharmacy Co., 309 Grand Avenue
Hall-Benedict Drug Co., Inc., 767 Orange Street
Hope's Drug Store, 341 Grand Avenue
Ideal Pharmacy, 137 Newhall Street
Kane's Pharmacy, 287 Dixwell Avenue
Kenney Edgewood Pharmacy, 1158 Whalley Avenue
Morris Cove Pharmacy, 101 Townsend Avenue
John L. O'Brien, 665 Grand Avenue
Proctor's Pharmacy, 180 Dixwell Avenue
Prospect Pharmacy, 586 Winchester Avenue
Roger Sherman Pharmacy, Whalley Avenue
Sachem Laboratories, 199 Whitney Avenue
Taft Pharmacy, 75 College Street
Taylor's Drug Store, 83 Grand Avenue
Edward A. Visel, 921 Elm Street
Washington Pharmacy, 105 Washington Avenue
Westville Pharmacy, 30 Fountain Street
Whalley Pharmacy, 1328 Whalley Avenue

WEST HAVEN

Cameron Drug Co., 114 Campbell Avenue
Center Pharmacy, 456 Campbell Avenue
Coughlan's Pharmacy, 65 Elm Street
Park View Pharmacy, 207 Orange Avenue

NORFOLK

Harry H. Cook, Greenwoods Road

SOUTH NORWALK

Professional Pharmacy, 45 West Avenue

NORWICH
Cooper's Drug Store, 1 Thames Street
Leone Drug Store, 50 Main Street
Lerou's Drug Store, 289 Main Street
Mara's Drug Store, 14 Franklin Street

PLAINVILLE
Plainville Pharmacy, 2 East Main Street

RIVERSIDE
Riverside Pharmacy, Post Road

ROCKVILLE
Arthur Drug Stores, Rockville

SEYMOUR
Foley's Drug Store, 11 Main Street

STAFFORD SPRINGS
Fournier's Pharmacy, 59 Main Street
McCormick Drug Store Co., 41 Main Street

STAMFORD
Bedford Drug Co., 269 Bedford Street
Maxwell's Pharmacy, Summer at Bridge Street

STRATFORD
Hamilton's Pharmacy, 3540 Main Street
Hausman's Pharmacy, 590 Success Street
Sears Pharmacy, 2392 Main Street

TERRYVILLE
Center Drug, Terryville
Pelchar's Pharmacy, 63 Main Street

THOMASTON
Latimer's Drug Store, 62 Main Street

TORRINGTON
Doyle's Drug Store, 257 South Main Street

UNIONVILLE
Paul F. Flynn, 2 School Street

WALLINGFORD
Modern Drug Store, 3 Hall Avenue

WASHINGTON DEPOT
Washington Pharmacy, Washington Depot

WATERBURY
Baldwin Pharmacy, 125 Baldwin Street
Bendler's Drug Store, 2 Congress Avenue
Brewster Pharmacy, North Main Street
Chase Park Pharmacy, 890 West Main Street
Fairlawn Pharmacy, 222 Frost Road
Fulton Park Pharmacy, 194 Cooke Street
Ideal Pharmacy, 178 North Main Street
John's Drug Store, 816 North Main Street
Kenausis's Drugs, 945 Bank Street
P. J. Kunkel Pharmacy, 1804 East Main Street
Lake Drug Co., 31 West Main Street
W. H. Pickett Drug Co., 738 North Main Street
Ray Drug Co., 1284 Baldwin Street
Rhinehart's Pharmacy, 471 North Main Street
Rielly and Burns, 340 North Main Street
Rareila's Pharmacy, 626 Bank Street
Vanderman Drug Co., 371 Main Street
Washington Hill Pharmacy, 838 Baldwin Street

WATERTOWN
Daniel G. Sullivan, 453 Main Street

WILLIMANTIC
Windham Pharmacy, 780 Main Street

WILSON
Wilson Drug Co., 396 Windsor Avenue

WINSTED
Opera House Pharmacy, Main Street

WASHINGTON
R. J. Benham, Inc.
C. Clayton Parks

Note: All Liggett Drug Stores and all Whelan Drug Stores in the State of Connecticut are also included.

A Britisher Looks at Medical Education in U. S.

Raymond Whitehead, D.SC., M.D., discusses "Medical Education in the United States" in a recent issue of the *British Medical Journal*. In his discussion Dr. Whitehead compares the system in our country with that in England and one gains the impression that, except for the high proportion of teachers to students in this country, he considers the British system preferable. For example, he does not approve of the preclinical teaching of pharmacology, pathology, and bacteriology but believes that they should be taught along with clinical medicine and surgery in studying the patient as a whole.

Dr. Whitehead comments on the different significance of examination results in the two countries. "The American student is judged on his knowledge, class work, and personality, the British student on his knowledge alone. A pass in a British examination means that the student has mastered the essentials of a subject; a pass in an American examination does not equally guarantee this, because a proportion of the marks may be awarded on grounds other than the demonstrated possession of knowledge."

There is a further comment on the intensive system of teaching in the United States, that it allows too little time for reading and rumination and denies him the relief of studying different subjects concurrently. Approval is expressed of our system of clinical-pathological conferences.

CORRESPONDENCE

Diabetes Detection Drive

The finding of the million unknown diabetics in this country poses a direct challenge to the American doctor. It is within his power to accomplish this feat. The existence of a million undiscovered diabetic patients in the United States has been demonstrated through a series of surveys, the most recent one conducted by the United States Public Health Service. The results of these studies now provide a springboard for organized medicine and a golden opportunity for physicians to seize the initiative *on their own* in this significant phase of public health.

The American Diabetes Association has planned a campaign to promote the early discovery and prompt treatment of the million undiscovered cases of diabetes. This campaign is unique in professional service, for according to plan the physician himself will be at the helm. Therefore, the plan cannot be prosecuted, or even started, without the endorsement and support of the entire medical profession through its governing bodies, national, state, county and local medical societies.

The plan proposed by the Association is simple, direct, and sure. Through local diabetes associations, related to the American Diabetes Association and with cooperation of local, county and state medical societies over the United States and Canada, it is planned to carry out blood-sugar screening tests by a new five-minute micro-blood sugar method with simultaneous urinalysis for sugar with attention to the time in relation to the preceding meal. The procedure can be carried out apart from a formal laboratory. The equipment is still in the manufacturers' hands but is to be available within two or three months. The only provision will be that the candidate must name a physician or clinic to which the results of the tests will be mailed for interpretation to the patient. Under no condition will a report be sent directly to the examinee. The effort is to bring the unknown diabetic patient under his own physician's care. There will be no statistics; no red tape.

Simultaneously, the American Diabetes Associa tion will carry on an intensive educational campaig directed first toward doctors' postgraduate course It will be directed toward the layman by radio newspapers and other publicity channels in additio to the *A.D.A. Forecast*, the Association's bi-monthl magazine which brings to the diabetic patient home spun articles on the disease by eminent authoritie in the field. At the same time the Association wil place in the hands of physicians over the country a authentic "Handbook of Therapy." Containing th most up-to-date information available, the Hand book will assist the physician in treating diabeti patients.

The week of December 6-12, immediately follow ing the interim meeting of the American Medica Association, will be proclaimed as "Diabetes Week." This will be the formal beginning, the kick-off, o the Association's Diabetes Detection Drive. Fron this start, the program will continue on a long tern basis.

The Association is determined to do its part i finding these million individuals and guiding then to you, their physicians, for treatment. May we count on your support when the matter comes up before your county or local medical society? The success or failure of the Diabetes Detection Drive depends upon you. You stand at the helm; this is your project.

Howard F. Root, M.D., Chairman

N. E. Surgical Society Meets in New Haven

The New England Surgical Society held its annual meeting in New Haven at the Brady Laboratory in New Haven on October 1, at which time the meeting was devoted to papers given by the New Haven representatives and the faculty of the Yale Medical School. In the afternoon there were interesting papers presented, and in the evening cocktails were served by Dr. Verdi for the entire membership and a dinner held at the New Haven Lawn Club. The final part of the program was held on October 2 at the Brady Auditorium. After the meetings lunch was held at St. Raphaels' Hospital and a number of the members went to the football game, others engaged in golf. This was a very interesting and profitable occasion.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Charles W. Goff, West Hartford
President-elect, Mrs. Ralph L. Gilman, Storrs
irst Vice-President, Mrs. F. Erwin Tracy, Middletown
Second Vice-President, Mrs. Charles H. Sprague, Bridgeport
Recording Secretary, Mrs. Paul Vestal, Woodbridge
Treasurer, Mrs. Frank DiStasio, New Haven
Corresponding Secretary, Mrs. J. Whitfield Larrabee, West Hartford

The State Board of Directors met at the home of Irs. J. Whitfield Larrabee with almost all the members present and full of enthusiasm for the plans to e made for the coming winter.

Mrs. Paul Tisher, public relations chairman, reorted that her committee has decided to carry out ie wishes of the National Woman's Auxiliary in eveloping urban and rural health programs. Our rst step in the state will be to promote the estabshing of adequate health facilities. Mrs. Tisher is olding a meeting of all county chairmen to correate county programs.

Chairman of the committee on legislation, Mrs. G. Gardiner Russell, reported that her committee is gathering data for the state session, which starts in anuary.

Mrs. Arthur Jackson, chairman on nurse recruitnent, is finding the best ways to help in this project. Plans are being made to have speakers at High Schools, P. T. A. meetings, club and church groups. Several of the counties have already established cholarship funds for the nurses, and it is hoped that nore can be done along this line.

The *Hygeia* chairman, Mrs. Dewey Katz, reported that her committee in cooperation with Mr. Paul Collier, of Youth Service of the State Department of Education, had sent a questionnaire to the principals of all secondary schools to find out: (1) how *Hygeia* is used in the schools, and (2) to introduce to schools the student group plan for the use of *Hygeia* as developed by the American Medical Association last year. The replies to the questionnaires had not been satisfactory and a second simplified one is now being sent.

Mrs. Goff announced that the semi-annual meeting of the State Auxiliary will be held at New Haven Country Club, on November 10. Registration is to be at 11:30 A. M., lunch at 12:30 P. M., followed by speaker and business meeting. Mrs. Charles H. Sprague, program chairman, reported that she has secured for a speaker Dr. Helen Gilmore, who is the physician-in-charge of Psychiatric Inpatient Clinic of the Grace-New Haven Community Hospital University Service. Her subject is to be "Psychiatry Has a New Look." It is hoped that a large number of members will attend this meeting and luncheon which will be both stimulating and instructive as well as a very pleasant social occasion.

Mrs. Larrabee entertained the Board at a delicious buffet lunch.

Fairfield County

A Board meeting was held at the home of Mrs. Meyer Abrahams in New Canaan, 14 members were present. Reports of various committees were given. Mrs. William Geer and Mrs. Chester Haberlin, co-chairmen of the ways and means committee, reported on the progress of the dinner dance at Cobb's Mill, Westport. Also other means of adding to our rehabilitation fund for Laurel Heights were discussed. Mrs. Booe, president, expressed the appreciation of the patients at Laurel Heights for the power sewing machine recently made possible by the Auxiliary. Following the meeting Mrs. Abrahams served a delightful lunch.

Hartford County

Plans are underway for a busy fall and winter for the county Auxiliary. The first Board meeting was well attended, Mrs. James Stretch and Mrs. James Cullen were hostesses at luncheon followed by business meeting. The resignation of Mrs. E. G. Higgins of Manchester as secretary was accepted with regret. Mrs. Henry Rollins of West Hartford was elected by the Board. Two new members of the Board were appointed: Mrs. C. C. Burlingame of Hartford as historian, and Mrs. Arthur Unsworth of West Hartford to head the postwar planning committee. The scholarship committee announced with pride that two scholarships have been awarded:

one to a medical student and the other to a student nurse. Several money raising projects are planned for the scholarship fund and the welfare fund, and every member will have the opportunity to help in some way. The semi-annual meeting will be held at the Hartford Golf Club, Dr. Helen Kelleher, Professor of Education, New York University, will be the speaker.

New Haven County

A Board meeting was held at the home of Mrs. J. H. Green of Waterbury. Reports were given by committee chairmen, and plans for the fall meeting were discussed. The Auxiliary plans to work in cooperation with the nursing schools of the hospitals in the county in recruiting nurses. Mrs. Alfred Wilson is chairman of the nurse recruitment committee. Mrs. Alexander Bassin, chairman of the volunteer committee, and members of the Auxiliary helped with clerical work during the chest x-ray program in New Haven. Tea was served after the meeting.

New London County

The Auxiliary sponsored a benefit bridge at Lighthouse Inn, New London, to raise funds to establish a scholarship fund for two student nurses, one to enter training at W. W. Backus Hospital in Norwich and one at Joseph Lawrence School of Nursing in New London. Eleven hundred dollars was realized with approximately 400 women attending. Dr. Henry Archambault, president of the County Medical Association, and Mrs. Julian G. Ely, County Auxiliary president, expressed gratitude to everyone who helped to support the bridge, therefore contributing to its success. Mrs. Eric H. Blank was chairman of the bridge committee with co-chairmen Mrs. E. L. Douglass and Mrs. J. F. Brosnan.

Windham County

A Board meeting was held at the home of Mrs. W. M. Shepard in Putnam. It was decided that the fall meeting will be held in Pomfret Inn, business meeting preceding dinner and a speaker on nurse recruitment. Mrs. Cecil Garcin, chairman on nurse recruitment discussed the organization of her committee and suggested several possible programs, stressing the educational for girls and boys in th eighth grade on opportunities offered by the pro fession. Mrs. Dinolt suggested that we also supply information on schools for laboratory technician of which there is such a shortage. Mrs. C. Bake outlined plans for collection of Christmas gifts t send to Norwich. Mrs. Arnold reported that "Wha to do about the criminal insane" has been given t Windham county as a special interest by state legis lation chairman Mrs. Russell. Revision of the con stitution will be presented at the fall meeting. Mrs Rowson, public relations chairman, was instructe to write to the County Medical Association to ask them if they wished us to put time and effort int another Health Day in spring.

Diamond Jubilee of Nursing

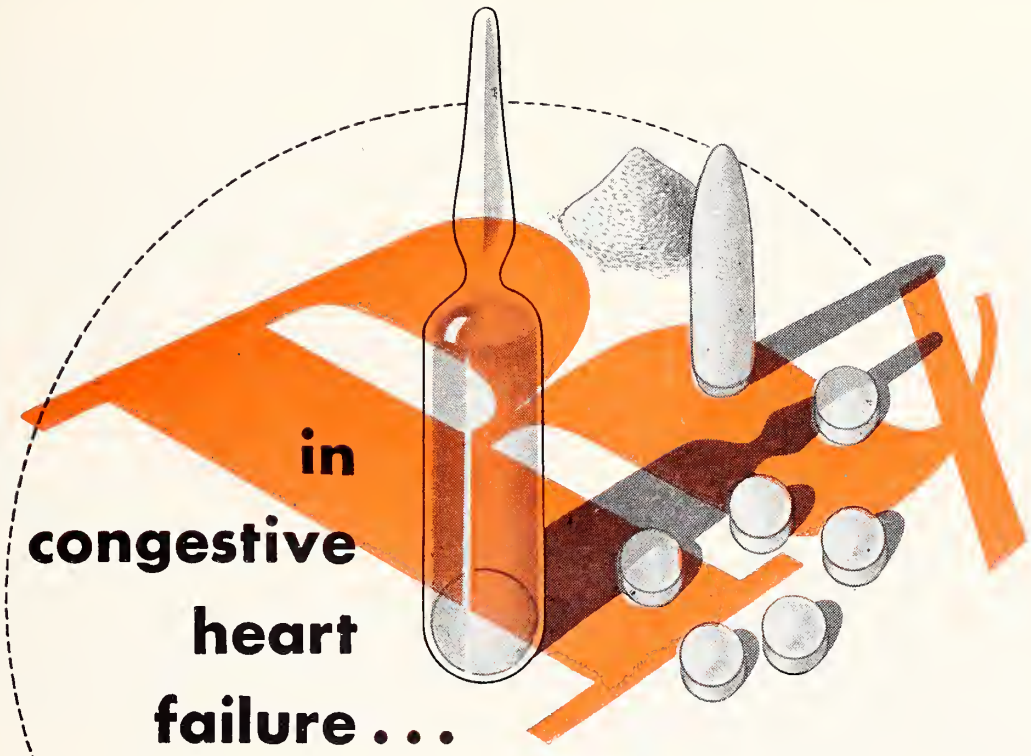
A coast-to-coast program of activities highlighting the history and progress of nursing to the present day, and paying tribute to the 320,000 registered professional nurses of America, will be initiated during Nursing Progress Week, November 14 to 20. On November 16 the Diamond Jubilee of Nursing will be celebrated by a Linda Richards banquet in New York City. Linda Richards has been called the Florence Nightingale of America.

It is hoped that the Jubilee will effectuate the recruitment of the 40,000 additional students for approved schools of nursing, desperately needed if professional nursing needs are to be met.

New Zealand Declares a Truce

For 7 years the medical profession and the government of New Zealand have been accusing each other of various crimes in the operation of the government medical care program. Now each has declared a truce in an endeavor to revise the program and make it workable.

The costs of medical services to the taxpayers rose from $8,000,000 in 1942 to $20,000,000 in 1947. The chief drawback of the plan is its failure to provide against the catastrophic expenses of major surgery. The average patient gets in return for his heavy tax payment only routine treatment from his physician, hospitalization in a public institution already overcrowded, and free drugs from his pharmacist.



in congestive heart failure . . .

"Aminophyllin may be given in the form of rectal suppositories (0.25 to 0.5 Gm.) or intravenously (0.24 Gm. in 50 cc. of fluid, 0.48 Gm. in 100 cc. of fluid), both for its diuretic effect and for its bronchodilating action, which relieves dyspnea."[1]

SEARLE AMINOPHYLLIN*

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

—meets the various dosage form requirements for congestive heart failure, bronchial asthma, paroxysmal dyspnea and Cheyne-Stokes respiration. It is supplied for oral, parenteral and rectal use.
G. D. Searle & Co., Chicago 80, Illinois

SEARLE

Research in the Service of Medicine

1. Orgain, E. S.: The Treatment of Congestive Heart Failure, North Carolina M. J. 8:125 (March) 1947.

*Searle Aminophyllin contains at least 80% of anhydraus theaphylline.

SPECIAL NOTICES

CONNECTICUT VA MEDICAL SOCIETY

The second annual dinner meeting of the Connecticut Veterans Administration Medical Society will be held on Thursday, November 4 at 7:00 P. M., at Les Shaw's, West Hartford Center.

The guest speaker for the evening will be Gerald Klatskin, M.D., assistant clinical professor of medicine, Yale Medical School, attending physician, Grace-New Haven Community Hospital, consultant in gastroenterology, Newington Veterans Hospital. His subject will be "Needle Biopsy of the Liver."

On November 18, at the regular Thursday meeting at the Veterans Administration Building, 95 Pearl Street, at 8:30 A. M., Robert Hepburn, M.D., assistant urologist, Hartford Hospital, will speak on "Kidney Injuries."

There will be no meeting on November 11 and November 25, because of the legal holidays.

The following clinical conferences will be held during November at the Veterans Administration Office, 355 Fairfield Avenue, Bridgeport, from 8:30 A. M. to 9:30 A. M. on the dates indicated:

November 3, 1948

Diagnostic Sigmoidoscopy—Case Demonstration

Joseph C. Quatrano, M.D.—assistant surgeon in proctology at St. Vincent's Hospital, Bridgeport

November 10, 1948

Discussion of Common Dermatoses

Ralph K. Parker, M.D.—dermatologist, Bridgeport

November 17, 1948

Therapy of the Anxiety Neurosis

Jacob Meshken, M.D.—neuropsychiatrist, Bridgeport

November 24, 1948

Suction Socket Above-knee Artificial Limb

Joseph J. Bruno, M.D., New Haven, chief medical officer, Bridgeport Veterans Administration Office

CONNECTICUT CONFERENCE OF SOCIAL WORK

The 38th Annual Session of the Connecticut Conference of Social Work will be held at the Hotel Bond, Hartford, November 4 and 5. The first day will be given over to general sessions including section meetings, the second day to institutes.

INTERNATIONAL MEDICAL ASSEMBLY

A Postgraduate School, Inter State Postgraduate Medical Association of North America. November 9, 10, 11, and 12. Public Auditorium, Cleveland, Ohio.

DR. TORBJOERN CASPERSSON OF NOBEL INSTITUTE, STOCKHOLM, ANNOUNCED AS SALMON LECTURER

The Salmon Committee on Psychiatry and Mental Hygiene has announced the Sixteenth Series of the Thomas William Salmon Lectures to be given by the distinguished Swedish biophysicist and biochemist, Dr. Torbjoern Oskar Caspersson, Professor of Medical Cell Research and Genetics and Director of the Institute for Cell Research of the Medical Nobel Institute in Stockholm. The series will be presented in Hosack Hall at the New York Academy of Medicine in New York City on the evenings of Monday, November 8, Tuesday, November 9, and Wednesday, November 10.

Under the general title of "Cell Function and Cell Growth in Normal and Pathological Conditions, Studied by Quantitative Cytochemical Procedures," Dr. Caspersson will describe his original research at the Karolinska Institute which is a division of the Medical Nobel Institute.

STATE SOCIETY OF ANESTHESIOLOGISTS

The Connecticut State Society of Anesthesiologists will meet at Hartford Hospital November 30 at 8:15 P. M. Dr. James C. Fox, Jr. of Hartford, will present a paper on "Sensory Dermatomes with Methods of Testing," and there will be case discussions presented by the Anesthesia Study Commission. All interested physicians are invited to attend.

FIRST COMPREHENSIVE DISPALY OF RADIATION DETECTION INSTRUMENTS

The first comprehensive display of radiation detection instruments, essential to the industrial, medical and biological applications of nuclear energy, will be presented at a conference on electronic instrumentation in nucleonics and medicine in New York, November 29 through December 1, according to an announcement by Adrian Dahl, Chief, Radiation Instruments Branch, U. S. Atomic Energy Commission, Oak Ridge, Tennessee.

The conference will be sponsored by The Institute of Radio Engineers and the American Institute of Electrical Engineers. Chairmen of the three day program will include Dr. W. A. Geohegan of Cornell University Medical College; Dr. G. W. Dunlap of the General Electric Company; and Dr. H. H. Goldsmith of the Brookhaven National Laboratory.

The exhibit of the U. S. AEC will include 22 types of basic instruments for radiation detection, identified by fabulous names including Juno, Zeus Meter, Cutie Pie and A C Poppy. These instruments, manufactured by 20 commercial companies, are typical of about 125 now in use, including components and others closely related to those in the display.

ONE PATIENT EVERY DAY

If every doctor in Connecticut spent a few minutes each day explaining to but one patient why medicine must remain free, more than 15,000 people could be reached every week.

A twelve-month program would spread this vital message to more than 750,000 people in the most valuable way it can be done.

There is no Substitute
For Personal Contact

The purpose of the conference will be to show the unique problems facing the utilization of atomic energy and the need for cooperation and understanding between the electronics engineer, the physical scientist, and the medical doctor. In addition to the instrument display the U. S. AEC is planning to participate with exhibits showing other instrument techniques which will be demonstrated by means of cut-away models.

The program will include more than a score of papers presented by leading authorities active in development of various phases of research and development of atomic energy for commercial and scientific application.

AMERICAN FEDERATION FOR CLINICAL RESEARCH

The Eastern Section of the American Federation for Clinical Research will hold its annual meeting in Philadelphia on Saturday, December 4, 1948 at the Temple University School of Medicine.

PROPOSED SCIENTIFIC PROGRAM AT INTERIM SESSION

NOVEMBER 30 - DECEMBER 3, 1948

Auditorium, St. Louis

Tuesday, November 30, 1948

P. M.

2:00 Lecture in Opera House on Hypertension
Irvine H. Page, Cleveland

2:30 Lecture in Opera House on Problems of Delivery
Ralph Reis, Chicago

3:00 Intermission

3:30-5:00 Clinical Presentations on Obstetrics in Room S-1; Poliomyelitis in Room S-2; Arthritis in Room S-3; Cancer in Room S-6; Radiology in Room S-7; Laboratory in Room S-8, and Hypertension in Room S-10

Wednesday, December 1, 1948

A. M.

9:00 Lecture in Opera House on Pediatrics
(Speaker to be announced)

9:30 Lecture in Opera House on Position of the Laboratory in the Diagnosis and Control of Disease
F. W. Konzelmann, Atlantic City, N. J.

10:00 Intermission

10:30-12:00 Clinical Presentations on Pediatrics in Room S-1; Poliomyelitis in Room S-2; *Diabetes in Room S-3; Dermatology in Room S-6; Radiology in Room S-7; Laboratory in Room S-8, and Hematuria in Room S-10

P. M.

2:00 Lecture in Assembly Room 1 on Arthritis
(Speaker to be announced)

2:30 Lecture in Assembly Room 1 on Common Skin Diseases
Everett Fox, Dallas, Texas

3:00 Intermission

3:30-5:00 Clinical Presentations on Obstetrics in Room S-1; Poliomyelitis in Room S-2; Diabetes in Room S-3; Cancer in Room S-6; Radiology in Room S-7; Laboratory in Room S-8, and Heart in Room S-10

Thursday, December 2, 1948

A. M.

9:00 Lecture in Opera House on Hematuria
(Speaker to be announced)

9:30 Lecture in Opera House on Jaundice
Sidney Portis, Chicago

10:00 Intermission

10:30-12:00 Clinical Presentations on Pediatrics in Room S-1; Poliomyelitis in Room S-2; *Diabetes in Room S-3; Dermatology in Room S-6; Jaundice in Room S-7; Laboratory in Room S-8, and Hematuria in Room S-10

P. M.

2:00 Lecture in Opera House on Diagnosis and Early Treatment of Poliomyelitis
Thomas Gucker, Boston

2:30 Lecture in Opera House on Heart
George R. Herrmann, Galveston, Texas

3:00 Intermission

3:30-5:00 Clinical Presentations on Obstetrics in Room S-1; Poliomyelitis in Room S-2; Diabetes in Room S-3; Cancer in Room S-6; Jaundice in Room S-7; Laboratory in Room S-8, and Heart in Room S-10

Friday, December 3, 1948

A. M.

9:00 Lecture in Opera House on Cancer
C. P. Rhoads, New York

9:30 Lecture in Opera House on Diabetes
E. P. Joslin, Boston

10:00 Intermission

10:30-12:00 Clinical Presentations on Pediatrics in Room S-1; Poliomyelitis in Room S-2; Arthritis in Room S-3; Dermatology in Room S-6; Jaundice in Room S-7; Laboratory in Room S-8, and Hematuria in Room S-10

*10:00 A. M. to 1:00 P. M.

The Connecticut State Medical Journal

Has made arrangements through its Journal to secure MEDICINE OF THE YEAR for those of its members who wish to subscribe. MEDICINE OF THE YEAR is an annual review of medical progress which will appear as a supplement to the Journal early in 1949. It will be a descriptive and analytical account of progress in medical science and practice during the preceding year presented in a practical, useful, and informative manner, particularly as it relates to the everyday practice of general medicine and the specialties.

The editorial management is under the direction of Dr. John B. Youmans, Dean, College of Medicine, University of Illinois. The principal contributors and their subjects are the following well-known medical educators and writers:

Internal Medicine—Dr. Hugh J. Morgan, *Professor of Medicine, Vanderbilt University, Nashville, Tennessee.*

Obstetrics—Dr. Frank Whitacre, *Professor of Obstetrics and Gynecology, Memphis, Tennessee.*

Pediatrics—Dr. Henry G. Poncher, *Professor of Pediartics, University of Ilinois, Chicago, Illinois.*

Surgery—Dr. Warren H. Cole, *Professor of Surgery, University of Illinois, Chicago, Illinois.*

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OUR NEIGHBORS

Massachusetts

The new director of the Thorndike Memorial Laboratory, Boston City Hospital, is William Bosworth Castle, professor of medicine at Harvard Medical School. Dr. Castle is the third director of the Laboratory since it was established 25 years ago.

Through the efforts of the Planned Parenthood League of Massachusetts the question of legalizing contraceptive aid to married women by physicians will be placed on the November ballots in that state.

New York

NEW WORKMEN'S COMPENSATION FEES

The new Workmen's Compensation medical fee schedule for New York went into effect September 1, 1948. It grants a general increase in fees and contains a great many service specifications, not included in the previous minimum medical fee schedule.

There are new items in connection with therapeutic and diagnostic procedures in anesthesia and plastic surgery, as well as allergies. Expansion of items is noted in connection with otolaryngology, ophthalmology, neurology, neurosurgery and urology.

Surgical fees in most instances have been increased, and the much debated fee for operative repair for single hernia has been increased to $100; bilateral $125. The fee for single recurrent hernia is $150, and recurrent double hernia $175. Herniotomies have an aftercare period of 4 weeks.

The fee for office visits for specialists has been raised to $5. The consultation fee has been raised from $10 to $15. The office diagnostic consultation fee for neurologists and neurosurgeons has been increased to $10. A $10 consultation fee is allowed for anesthetists and physical therapists—and a $15 consultation fee for allergists.

Laminectomy and spinal fusion came into the picture, and the fee schedule states emphatically that these procedures can be carried out only after specific authorization of the insurance carrier or employer.

Fees for fractures include application of casts at the time of reduction, and provision is made for reapplication of casts.

The new fee schedule for injections allows th regular office visit fee, plus the cost of the drug, fo subcutaneous injections; the office visit fee, plus $1 plus the cost of the drug, for intramuscular or dee injections; and $5 plus the cost of the drug, fo intravenous injections. Penicillin and vitamin injec tions are A. & A.

* * * *

The Medical Society of the State of New Yor experienced a deficit of $96,538.11 for the year end ing December 31, 1947. The Society's *Journal* con tributed to the Society $5,076.05 to which wa allocated from dues $52,335 for the publication o the *Journal*. This net operating income from th *Journal* of a little over $5,000 represented about ⅓ of the net operating income for 1946 and about ⅓ for 1945.

Dr. William L. Watson, chief surgeon of th Thoracic Surgical Service of the Memorial Hospita Center for Cancer and Allied Diseases, has beer appointed associate professor of surgery at New York University College of Medicine and will ac as coordinator of the teaching of cancer through out the medical school, Chancellor Harry Wood burn Chase of the University announced recently

In the new post Dr. Watson will be the directo of a tumor clinic for the care and study of cance patients of the New York University services o Bellevue Hospital. He will also continue in his post at Memorial Hospital and handle all aspects of th teaching program of the College there.

Dr. Homer W. Smith, chairman of the Depart ment of Physiology of the New York University College of Medicine, has been awarded the Meda for Merit, the President's highest award to civilians. The Medal was presented jointly by the Army and Navy at a ceremony in New York City, which concluded Medal for Merit awards made to scientists and engineers throughout the nation. Dr. Smith was the winner of a Lasker award in 1947 for outstanding work in public health.

Dr. Thomas D. Dublin has been appointed executive director of the National Health Council. Dr. Dublin comes to the Council from the Long Island College of Medicine, Brooklyn, where he has served during the last six years as professor of preventive medicine and community health.

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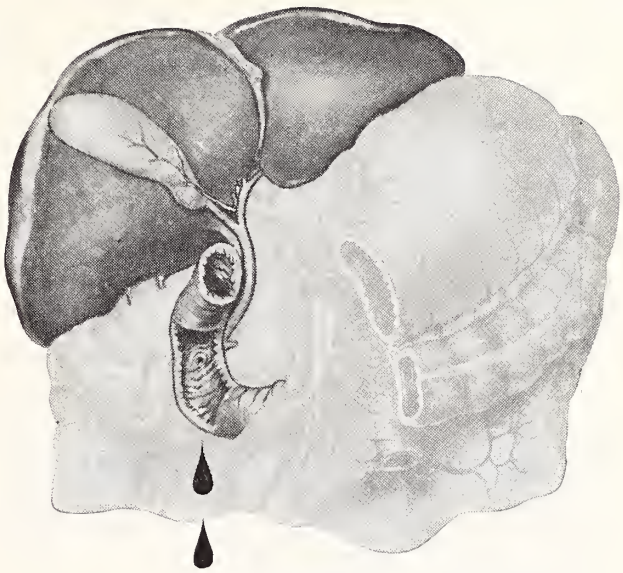
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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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NEWS
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Fairfield

Louise D. Larimore, for 20 years pathologist at Greenwich Hospital, committed suicide in her office in Greenwich on September 21. In 1937 Dr. Larimore received an award from the Women's Hospital, Philadelphia, for her invention of a portable, high-powered microscope. Dr. Larimore was noted for her work in the field of allergy. She was also an expert cook and owned the largest collection of perforated stamps in the United States.

Robert W. Nespor, a practising physician in Westport for the past 11 years, has been appointed health officer of that town to succeed Dr. C. W. Gillette.

Hartford

Fanny Karp Radom of West Hartford, for 30 years a practising physician in Hartford, died at her home on September 12 after a long illness. Dr. Radom was one of the first women to be licensed as a pharmacist in Connecticut. She was also one of the founders of Mt. Sinai Hospital, Hartford.

In expanding its research program in electroencephalography and allied studies, the Institute of Living has secured the services of Dr. Charles E. Henry to direct the program. Dr. Henry has been brought to Hartford from the Institute of Juvenile Research in Chicago. It is expected that with the completion of the new Institute of Child Psychiatry, Dr. Henry will be directly associated with the program to aid those with juvenile mental disorders.

Arthur S. Brackett of Bristol is the author of Enteric Colic (in young infants) published in *The Yale Journal of Biology and Medicine,* July 1948.

William Levy, a practitioner in Suffield for the past 35 years, died at his home on September 15. Dr. Levy was local medical examiner and health officer for 10 years, resigning because of ill health. He served for many years on the staff of the Springfield (Mass.) Hospital.

Ellen Pembroke O'Flaherty, former president of the medical staff of St. Francis Hospital and former vice-president of the Hartford Board of Health, died at her home in Hartford on October 6.

Litchfield

The semi-annual meeting of the Litchfield Cour Medical Association was held at the Torringt Country Club on Tuesday, October 5, 1948. T meeting was preceded by a social hour and a ste dinner.

The Association was honored by the presence numerous guests. Samuel C. Harvey, president of t State Medical Society, brought greetings from t parent organization and spoke briefly. Creight Barker, executive secretary of the State Medi Society, gave a very interesting report of conditic as he found them in Germany on his recent tr Among other things, he stated that there we about 10,000 doctors in Germany doing nothing a that the country was well supplied with physicia but that the quality of the medical service was po Dr. Barker answered a few pertinent questions, b it is to be regretted that insufficient time did n permit further discussion. Stanley B. Weld, edit of the CONNECTICUT STATE MEDICAL JOURNAL, spo briefly on some of the problems and plans of t JOURNAL and urged the support of the medical pr fession. Stanley H. Osborn, Commissioner of t State Health Department, gave a very interesti and most scientific discourse on "Appendicitis." H also commented briefly on the plans of the Sta Health Department to increase its scope next yea if sufficient funds are provided by the legislatu to do diagnostic Papanicolaou stains and Rh's. Lou E. Gold returned to his native county for the mee ing and brought the greetings of Fairfield Count John E. Kelley of Norwich was the delegate fro New London County.

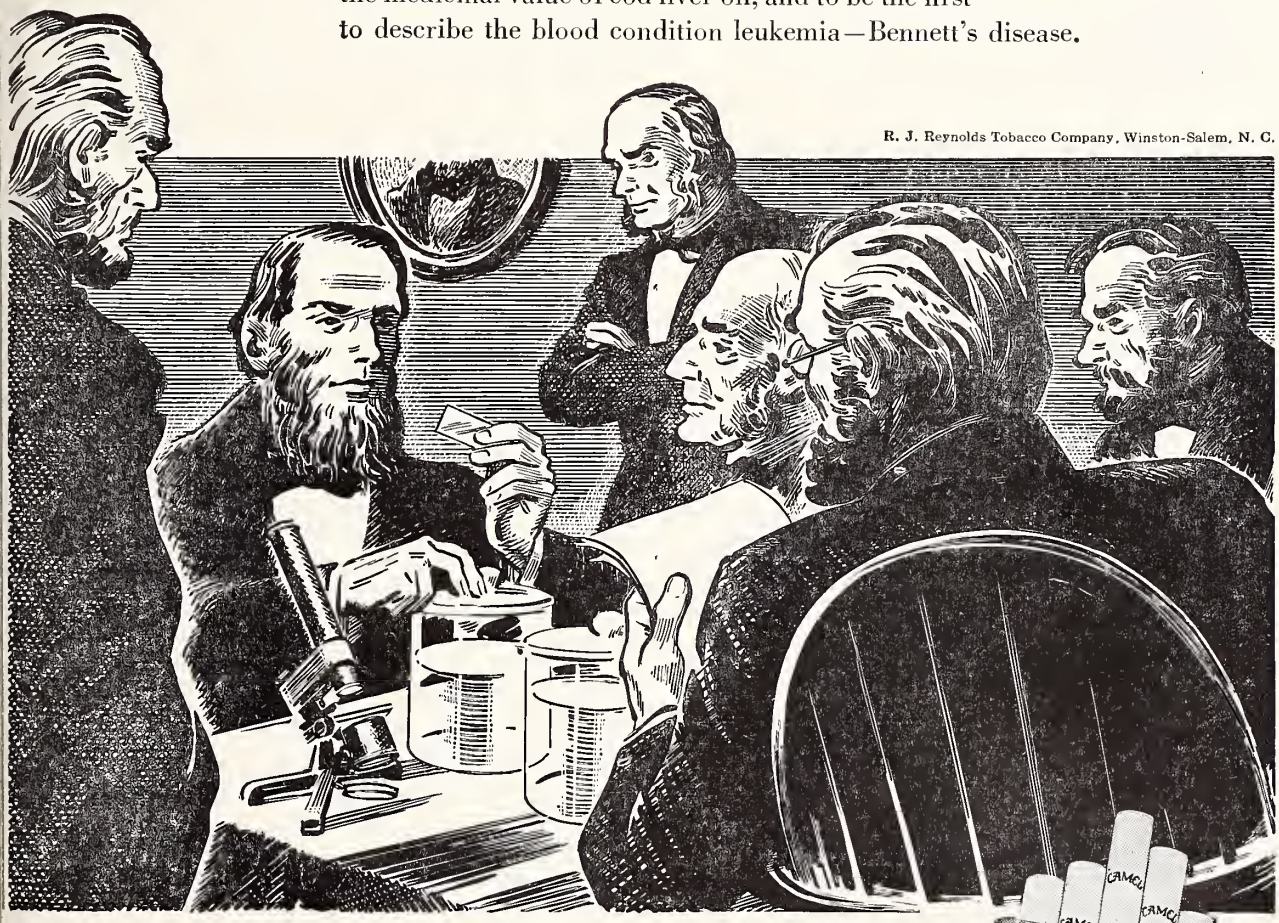
The business meeting was conducted by the pres dent, Frank L. Polito. The secretary-treasurer report was given by Thomas J. Danaher and th obituary of Dr. Elias Pratt, written by Sanfo Wadhams, was read. Reports of the censors, th councilor, and the committee on ethics and depor ment were heard and accepted without commen George L. Cushman of North Woodbury a gradu ate of Tufts Medical School, class of 1939, w admitted to membership. Changes in the by-law recommended at the annual meeting by the com mittee appointed some time previous to study th organization and objectives of the Litchfield Count Medical Association, were read and approved. D Danaher reported on the progress of his committe which is studying the Connecticut Prepaid Medica Care Plan. Dr. Barker assisted Dr. Danaher i

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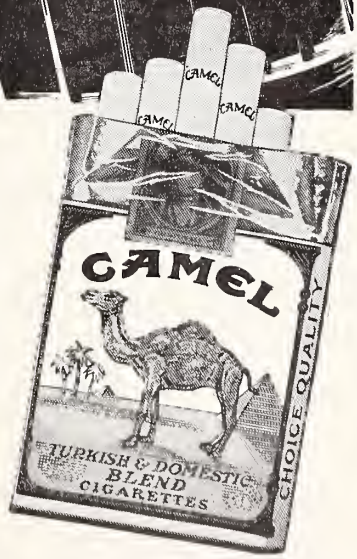
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answering the numerous questions concerning the provisions of this Plan and complimented Dr. Danaher on the clearness and fairness with which he presented the subject to the Association. The meeting was adjourned at about 9:00 P. M.

* * * *

The meeting of the Litchfield County Chapter of the American Academy of General Practitioners was held at the Torrington Country Club on October 5, following the semi-annual meeting of the Litchfield County Medical Association.

The meeting was presided over by its president, J. F. Kilgus, Jr. of Litchfield, and it was announced that the charter had been received from the State Organization and that the Litchfield County Chapter was the first to receive such a charter.

It was voted to endorse the Plan for Prepaid Medical Care presented by the State Medical Society and to offer the committee responsible for drafting this Plan its wholehearted support and cooperation. It is realized that in its present form the general practitioner will not be greatly assisted by such a Plan, but the organization believes that this is a step in the right direction in hopes that, once the Plan has been brought into operation, it can be liberalized to include more strictly medical conditions, which constitute the bulk of the general practitioner's practice.

Considerable interest was expressed in the scientific meeting to be held by the American Academy of General Practice in Cincinnati next March. Quite a number of the members from Litchfield County are planning to attend.

A discussion of postgraduate work available for general practitioners in this State was one of the items on the agenda. A considerable number of the members of the Litchfield County group are taking advantage of the postgraduate studies offered by Yale University and it is hoped that in the near future some sort of postgraduate program can be brought into the County, which will enable all of the general practitioners to take advantage of this work.

The next regular meeting is planned for January, either following or preceding the January County Association meeting. Meanwhile, the executive committee and various other committees are busy planning for future activity.

New Haven

Louis J. Thibault, formerly a school physician Waterbury, died at St. Mary's Hospital in that ci on September 12. Dr. Thibault was a member of t staff of St. Mary's Hospital and up to the time his last illness had been health officer for the tov of Wolcott.

James D. McGaughey, III, has been appoint assistant medical examiner for the town of Wallin ford.

Seymour L. Spier, a practitioner in New Have for about 40 years, died at Undercliff Sanatorium September 22.

Gustaf Lindskog was the guest speaker at t October meeting of the Bristol Hospital Medic Society. His subject, "Surgical Diseases of t Oesophagus."

On October 5, a dinner was given for Dr. Georg Blumer by the staff at St. Raphael's Hospital.

Mila E. Rindge of Madison has joined the Sta Department of Health as an epidemiologist in t Bureau of Preventable Diseases. Dr. Rindge, who the daughter of Dr. Milo Rindge, has been actin assistant health officer for Madison for the past years.

William Dameshek, professor of medicine Tufts Medical School, was the September speake at the Waterbury Medical Association. He spoke o "Hematology" to the largest gathering in the his tory of the Association. Discussion was carried o by local members and visitors from New Haven.

Samuel C. Harvey was the principal speaker a the annual meeting of the State Cancer Society hel at the Waterbury Country Club. Dr. Harvey ex plained the workings of the National Cancer Insti tute as they are carried on in Connecticut. Report were given by other officers and Creighton Barke was re-elected president.

Arthur J. Geiger spoke to the Waterbury Hear Society at its monthly meeting on October 7. H discussed the "Diagnosis of Surgically Correctabl Cardio-Vascular Disorders."

I. C. Rubin of the Bellevue Medical School o New York was the speaker at the October meetin of the Waterbury Medical Association. He gave very interesting discussion on "Problems in Infertil ity and Sterility."

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THE CONNECTICUT STATE MEDICAL JOURNAL

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NEW BOOKS IN REVIEW

STANDARDS FOR THE DIAGNOSIS AND TREATMENT OF CANCER. By the Cancer Committee of the Iowa State Medical Society. Iowa: Athens Press. 1948. 160 pp. $1.

Reviewed by MATTHEW H. GRISWOLD

Written for the general practitioner, this cancer manual supplies a fund of valuable information in a form admirably suited for easy reference.

The chapter entitled "The Cancer Problem and the Family Doctor" is packed with information and advice dealing with lay and professional education, poverty as a reason for delay in coming for treatment, and general care of the patient with advanced cancer, with adequate attention to the control of pain and the support of the patient's morale. It is refreshing in its brevity and sufficient in the amount of information it contains.

The chapters dealing with cancer in the major anatomical subdivisions of the body furnish information on early and late signs and symptoms, diagnosis, treatment, and prognosis. Where indicated, varieties of cancer and etiology are discussed. The final chapter deals with radiation therapy. Some warning as to the dangers inherent in the promiscuous use of radiation could well have been given prominence in this chapter.

A rather voluminous bibliography ends the volume and should prove a great help to those desiring to pursue their investigations beyond the scope of the manual.

The manual is concise, logical, well written and as accurate as our present knowledge permits. It should prove to be a valuable tool for the use of the general practitioner.

CORRELATIVE NEUROANATOMY. (Fourth Edition, Revised.) *By Joseph J. McDonald,* M.S., M.SC.D., M.D., *Joseph G. Chusid,* A.B., M.D., *Jack Lange,* M.S., M.D. *Palo Alto, California: University Medical Publishers.* 1948. 156 pp. $3.

Reviewed by HAROLD S. BURR

The first edition of this manual appeared in 1938. The copy at hand is from the second printing of the 4th edition, March, 1948. This is a pedestrian dictionary of structure of the nervous system, coupled with signs and symptoms. It is not a text and could not be read intelligently by the beginning student, and is far too simple for the clinical neurologist. Conceivably it might be useful for the general practitioner with a limited acquaintance with the nervous system who wanted to brush up on some of the practical aspects of neurological disorders. It covers a very extensive field in the kind of shorthand used chiefly by experts. This is an off-set edition with surprisingly good illustrations for this type of publication. While many of them are over simplified they nevertheless can be useful to a student reviewing for Board Examinations. As a "trot" this book might be useful for certain types of minds but otherwise it is hard to see its value.

PHYSIOLOGIA COMPARATA ET OECOLOGIA. An International Journal of Comparative Physiology and Ecology. Vol. 1, No. 1, pp. 62, May 15, 1948. *The Hague: Dr. W. Junk.* fl. 36.

Reviewed by *Harold S. Burr*

Another new journal. This time an international one. Its prospectus asserts that it will publish articles in the general field of animal and marine biology, as well as comparative physiology. The volumes will avoid cellular, medical, or veterinary physiology and animal psychology. It is interesting, furthermore, to note that they will not publish articles of a polemic nature or those which are purely theoretical. It is clear, then, that the Journal must necessarily appeal to a very limited number of investigators. The price is 36 florins per volume, which is not conducive to widespread dissemination. However, it is edited by a distinguished group of biologists and one may expect a high standard of excellence. The format is pleasant and the paper excellent. The size, 13 x 20 cm. exclusive of margins, makes for a somewhat unwieldly pamphlet. The illustrations in this first issue are uniformly excellent, superior to much of the work done in this country.

The international character of the Journal is clear from the source of the five articles in this first issue. The first paper by Bullock is from the University of California in Los Angeles and discusses the giant nerve fiber in Annelids.

The second communication by Vonk and Postma of the University of Utrecht, presents the interesting results of x-ray studies in the movements of the hen intestine. Also from Utrecht is a paper by Romijn on respiratory movements of the chicken during the parafoetal period.

The fourth paper from the University of Liège is "Sur L'Osmoregulation de L'Anodonte," by Florkin and Duchateau. The last paper by Hediger, from the Zoological Gardens at Basel deals with the breeding of the European hare.

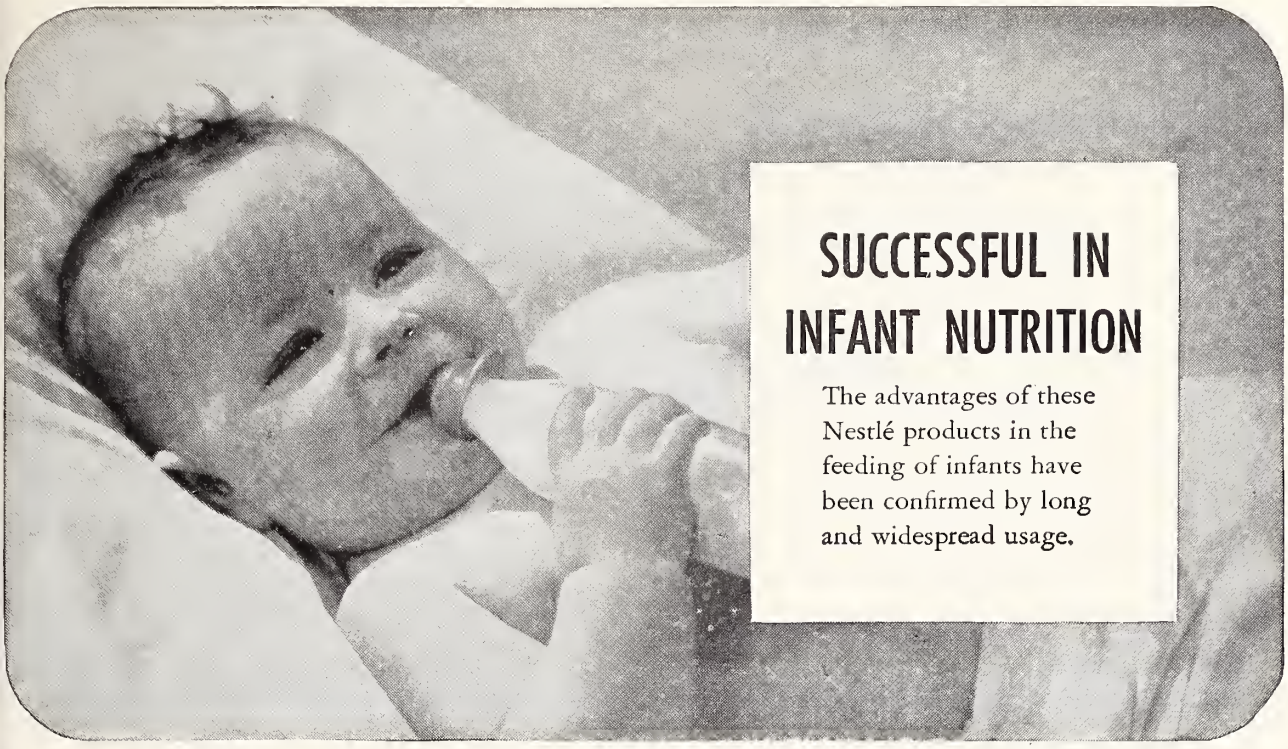
Fortunately for the Europeans, the first three papers in English have resumés in French. The fourth paper, written in French, has a summary in English. The last paper, which is in German, has a resumé in French, but not in English.

Very probably this new journal will fill a need for a small group of highly specialized investigators, but if we must have new journals it would be nice, someday, to find adequate coverage of the unifying elements in science instead of the persistent cutting of science into ever smaller fragments.

NOAH WEBSTER: LETTERS ON YELLOW FEVER ADDRESSED TO DR. WILLIAM CURRIE. With an Introductory Essay by *Benjamin Spector. Baltimore: The* Johns Hopkins Press. 1947. 110 pp. $2.

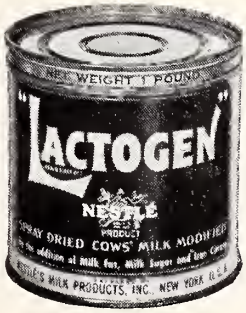
Reviewed by STANLEY B. WELD

The letters published in this supplement to *The Bulletin of the History of Medicine* appeared originally in the October, November and December issues of the 1797 *(New York) Commercial Advertiser.* They were not republished during the intervening 150 years. Their contents are important because of Webster's contribution to American medical thought and because they formed the basis and plan for



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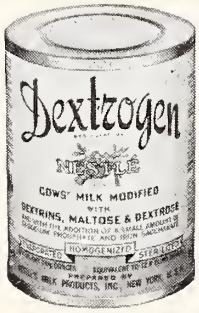
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his book, "A Brief History of Epidemic and Pestilential Diseases."

Noah Webster was born in West Hartford, a fact which should interest many Connecticut physicians. He is probably best known for his "An American Dictionary of the English Language." A practising lawyer, he turned to newspaper work and became an editor of a daily and of a semi-weekly newspaper in New York City. His versatility is exemplified by his contributions to the fields of politics, economics, political science and medicine.

These letters to Dr. Currie present a wealth of material to substantiate Webster's theory of infection. Although but a layman he had the boldness to disagree with the theory then in existence and offered plenty of proof to support his argument. He believed, as these letters show, that yellow fever did not arise in the West Indies nor the plague in Egypt or Constantinople. He believed that there existed a difference between infection and contagion and that epidemics were fostered by unhealthy environment. He proposed the construction of cities in such a way that the population would not be crowded and would not be exposed to low marshy ground.

Noah Webster made a valuable contribution to American medicine. His letters to Dr. William Currie supporting the principle of the Epidemic Constitution are the more remarkable because they were written, as Dr. Spector states in his introductory essay, "at a time when theory, empiricism and authority were dominent forces in medicine."

HANDBOOK OF ORTHOPAEDIC SURGERY. (Third Edition.) *By Alfred Rives Shands, Jr.*, B.A., M.D., Medical Director of the Alfred I. duPont Institute of the Nemours Foundation, Wilmington, Delaware; Visiting Professor of Orthopaedic Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania. *In Collaboration With Richard Beverly Raney*, B.A., M.D., North Carolina. *St. Louis: The C. V. Mosby Company.* 1948. 574 pp. with 159 illus. $6.

Reviewed by Paul P. Swett

The third edition of this Handbook (the first since 1940) is a welcome addition to orthopedic literature. When it was first published 10 years ago Dr. Shands modestly hoped his short textbook would find a permanent place in the teaching of orthopedic surgery. This hope has become a reality and his book is widely used by undergraduates and by graduates in medicine, as well as by general practitioners, nurses, physical therapists and other allied groups.

This concise textbook fills an important place in the requirements of both teachers and students. Conciseness sometimes is interpreted as brevity and lack of comprehensiveness. Here, however, compressed into 574 short pages, including the index and an extensive bibliography, is a thorough coverage of the entire field of orthopedic surgery, succinctly expressed, well illustrated, and splendidly organized. The excellent chapters on arthritis, on fracture deformities and on neuromuscular disabilities add greatly to the usefulness of this handbook for internists and general surgeons alike.

A reviewer can only express his thanks to Dr. Shands and his collaborator, Dr. Raney, for their signally successful effort to provide a book of such wide appeal and great usefulness.

GENERAL ENDOCRINOLOGY. (First Edition.) *By C. Donnell Turner*, PH.D., Associate Professor of Zoology at Northwestern University. *Philadelphia and London: W. B. Saunders Company.* 1948. 604 pp. with 164 figures $6.75.

Reviewed by Sophie A. Root

As Dr. Turner points out in the Preface, this book was written as a text and reference book for undergraduates at Northwestern who major in zoology or are taking pre-medical, predental, nursing, or pedagogic courses. It is not meant for practicing physicians primarily, and therefore does not aim to describe all the syndromes based on endocrine abnormalities, nor does it emphasize therapy. However, it will orient any reader most effectively in the field of invertebrate as well as vertebrate endocrinology, and in doing so it increases the understanding of human hormonal mechanisms. It is factually correct and absolutely up-to-date, and the style is lucid and simple, though not oversimplified. Many excellent diagrams and illustrations make the text easier to comprehend.

In reading the book very carefully I did not find even a typographical error, but one controversial point might have been treated at greater length: namely, Iodbasedow. Some endocrine workers do not agree that "the administration of iodine to persons with adenomatous goitres frequently converts a non-toxic into a toxic one." This impression, however, is quite widespread, so its inclusion as a fact is understandable.

The bibliography is extensive and the index accurate and detailed.

It is amazing that undergraduates are now expected to master so many details of the specialized field so well covered in this volume.

FAILURES IN PSYCHIATRIC TREATMENT. Edited by Paul H. Hoch, M.D., New York State Psychiatric Institute, N. Y. C. (The Proceedings of the Thirty-Seventh Annual Meeting of the American Psychopathological Association held in New York City, June, 1947. *New York: Grune & Stratton.* 1948. 241 p. $4.50.

Reviewed by C. C. Burlingame

This symposium on therapeutic failures with different methods of treatment in psychiatry is the work of numerous capable observers, all specialists in the areas whereof they speak. A book of this kind, dealing with failures rather than successes in psychiatric practice, is an innovation, one long needed however, both as a curb on over-zealousness and prejudice in the use of particular methods and as a guide to better criteria for selection of patients, for techniques of application, and for reporting of results.

The methods of treatment discussed are fairly comprehensive, in the sense that the major ones receive adequate attention. A good feature of the work is the discussion of

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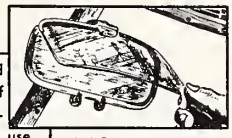
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each contribution by another specialist having broad experience in the field. The overall observation, critique and re-emphasis of guiding principles assures an excellent orientation for the topic under review.

Dr. Nolan Lewis introduces the symposium with a careful presentation of the basic issues, emphasizing such crucial points for therapeutic success or failure as the patient with whom one is dealing, the type of therapeutic approach selected, and the personality and individual approach of the therapist. The subjects covered in the volume are, specifically: psychoanalytic therapy; psychobiologic method; hypnosis; treatment of criminals; psychotherapy; of children; psychosomatic case treatments; group psychotherapy; heredity and constitution in relation to treatment; insulin shock therapy; electric shock therapy; prefrontal lobotomy; treatment of neurosyphilis; epilepsy; and social case work. Some of the contributions, for example those dealing with failures in hypnosis, neurosyphilis, insulin and electric shock treatment, contain more pointed lessons than others, mainly because they are based on a relatively greater backlog of experience, whereas we are still pioneering in such fields as criminology, child psychiatry, group therapy and prefrontal lobotomy. All the more timely and important, however, is the posing of problems and issues in the latter fields.

The editor of the volume, Dr. Paul Hoch, has done an excellent job in summing up the symposium findings, and in evaluating them in the light of personal experience. One of these findings is the great variation in the concept of therapeutic success and failure and the need for coming to basic agreement on what these terms connote. The same observation applies to the problem of diagnosis. Another important point emerging from the survey is the need for flexibility in psychiatric practice and for the discarding of dogmatic attitudes.

A handy reference tool for the clinical psychiatrist, this is also a valuable source book for researchers in the field. One hopes that its acceptance will be such as to invite parallel offerings at regular intervals in the future.

YOUR SKIN AND ITS CARE. By Howard T. Behrman, M.D., and *Oscar L. Levin*, M D., authors of *Your Hair and Its Care. New York: Emerson Books, Inc.* 1948. 255 pp. Illustrated. $2.50.

Reviewed by Ellwood C. Weise

Here is a book which should be read by any layman interested in the care of the skin. Its practical and scientifically sound approach to this problem is couched in simple language which unveils the mystery, charlatanism and high pressured advertising, through press and radio, which so befuddles the average person in his or her attempt to intelligently evaluate the problems involved in skin care. The sound advice contained in this book should do much to insure a healthy complexion by directing the reader's thoughts into proper channels, both as to the cause of the complaint, and as to the remedial measures necessary for its correction.

The authors discuss the logical approach as well as the systemic background for certain skin disorders and guide the patient as how best to cooperate with his physician or dermatologist.

The contents touch briefly upon the structure and physiology of the skin to give the layman a working insight into the chapters which follow. These include general health as it affects the skin, daily skin care, cosmetics, quackery and recent scientific discoveries. In addition, the various skin conditions having an endocrine etiology are discussed along with cutaneous infections and inflammations, moles, birthmarks, eczema, skin growths, and nervous eruptions. The chapter on the care of the hair carefully covers the subject of superfluous hair in women but only superficially deals with baldness in men. The reason for this latter fact is probably accounted for by the authors having adequately dealt with this subject in a separate manual.

To the lay individual, this book brings an accurate and unvarnished story of practical skin care and exposes quackery at every opportunity. Its conciseness and factual content might even appeal to the physician who does not practice dermatology but who occasionally might require a superficial working knowledge to guide his patients in the truths of this field.

THE INTEGRATIVE ACTION OF THE NERVOUS SYSTEM. By Charles S. Sherrington, D.SC., M.D., HON. LL.D. TOR., F.R.S., Holt Professor of Physiology in the University of Liverpool, Honorary Member of the American Physiological Society. *New Haven: Yale University Press.* 1948. 433 pp. $6.

Reviewed by Thomas C. Carey

To all those of the Physiological Society who have been responsible for the rebirth of this scholarly landmark in neurophysiology, a thousand thanks; to Sampson Wright, who was chosen to edit this special edition, a particular congratulation for not altering the original text and not attempting to improve on the genius of Sr. Charles Sherrington. As a matter of fact not one word of the original text has been changed. Only the worn out blocks and prints are "new" in that it was necessary to reproduce the original which had faded.

This landmark in neurophysiology was first published in 1906 and has had numerous reprints, the last being in 1920. Unfortunately for some years it has been unavailable, excepting to those who had previously obtained a volume a generation ago. Rarely does one so gifted as Sr. Charles Sherrington come across the medical horizon to experiment, to teach and write as only this great psysiologist and philosopher can. Why the printing of the original classics in medicine lapse is not understandable, insofar as the originals are so rarely improved upon. Sherrington's original experimental works are the basic cornerstones of such that we know today and have continued to accept as physiological fact in neurology, physiology, neurosurgery as well as other correlated branches in the psychological fields. Like other original experimental descriptions by such masters as Parkinson, Babinski, Hughlings Jackson, Cushing, Bailey, etc., they cannot be improved upon and to every student of medicine, physiology and psychology this text on the now well known fundamental facts of the reflex is a must. All medical schools should make it compulsory reading, as probably no book of the basic sciences in medical education has been so beautifully touched by genius.

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Supplement to
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CANCER FACILITIES IN CONNECTICUT

CREIGHTON BARKER, M.D., *New Haven*

The Author. *President, Connecticut Cancer Society; Executive Secretary, Connecticut State Medical Society*

THIS first Connecticut Cancer Conference is a mutual enterprise of the Connecticut Cancer Society and the Connecticut State Medical Society aided by the Yale School of Medicine, the State Department of Health and many individuals. Conferences of this kind have been held with success in many states and the Cancer Society is of course pleased to cooperate with the State Medical Society in making it possible to hold such a meeting in Connecticut. On behalf of the Cancer Society I am privileged to welcome you here and I am sure you will find the program interesting and valuable. After the meeting is over we hope you will comment on it to us so that future sessions may be improved to meet your wishes.

I want to thank you, Dr. Bristoll, and your associates on the Committee for the thought and effort you have put into arranging the program. Credit for the success of the Conference must go to you.

When these meetings were first thought of Dean Long invited us to hold them at the Yale School of Medicine. As our plans developed it was realized that the facilities at the School were not quite suited to our needs and we reluctantly moved the sessions to this hotel. We are grateful for the School's interest and helpfulness in many ways and regret that it was not practical to have the meeting there.

The discussion of the cancer facilities in Connecticut or any state must begin with physicians: the surgeon, radiologist, pathologist, pediatrician, health officer and, more important than any other, the family physician, who usually sees the patient first and whose opinion and recommendations are the basis for the patient's or his family's decision. In the light of present knoweldge if there is to be a decline in cancer mortality it will come first of all from early recognition of the disease by the general practitioner. The people go to him first for medical aid and their future depends upon his counsel. It is the family doctor who sees the most people and he has the best opportunity and broadest responsibility to give service and information which should lead to early diagnosis.

There often seems to be some magic in the word "clinic" and cancer detection centers and clinics certainly do attract people, but it is a statistically established fact that a large percentage of those cancers which respond to present day therapy may be at least presumptively diagnosed by careful physical examination without intricate diagnostic facilities. The Connecticut Tumor Registry shows that 67 per cent of all cancers occur in anatomical sites where thorough physical examination could disclose their presence, and extensive cancer case studies made by the New York State Department of Health established that in 73 per cent of the five year survivals the initial lesions were detectable by physical examination. The remaining 27 per cent, such as cancer of the stomach, lung and pancreas were to be determined only by special methods. In comparison with these cancers that require special and often expensive diagnostic procedures, lesions of the head and neck, breast, cervix and rectum may be recognized quite early in their course by a thorough physical examination. The five year survival rate for this group was found to be relatively high in the New York study.

There are other observations in support of the plea for careful physical examination and summarized they lead to the conclusion that two-thirds of

Presented at the State Cancer Conference, New Haven, March 25, 1948

all cancers and three-fourths of those responding to the therapy available can be detected by physical examination. It is the individual physician in his office that is the first line of defense.

Connecticut is peculiarly fortunate in having in its State Department of Health a Cancer Division that renders valuable service to physicians and the public and I do not refer alone to the now famous Connecticut Tumor Registry which sometimes overshadows other useful projects. I am indebted to Dr. Matthew Griswold for an outline of these services.

Since July 1, 1943 the Department has distributed $50,000 each year to hospitals for use as they see fit in tumor clinics. For two years prior to 1943 the annual amount distributed was $25,000. These funds, although perhaps not fully adequate, have been a guarantee of continuity of many basic services in the cancer field.

The Department, in cooperation with the Association of Tumor Clinics, has established an educational program which enables physicians to share what they have learned and increase their knowledge. Three or four times each year physicians from one clinic visit another and participate in it. Each visiting man receives a token fee of $25 and expenses. This program was begun in the fall of 1946 and already nearly 200 Connecticut physicians have taken part in it.

The Cancer Division has provided 20 hospitals with detailed analyses of their own cancer record experience. Members of the Division have discussed their statistics at staff meetings and emphasized their good points and this procedure has resulted in an increase of physician attendance at clinics and an improvement in important details of subsequent records.

Another service of value to hospitals and physicians is the automatic notification of death as soon as the death record is received. These records go in photostat to the Cancer Division within a month after they are received by the Bureau of Vital Statistics and are checked against the case index to see if the patient had been in any hospital and if so that hospital is notified.

These are some of the things done by the State Department of Health.

So many of you are familiar with the tumor clinics in the State that it is unnecessary for me to discuss them here. There are now 25 of these clinics meeting regularly and one that meets by appointment. As is to be expected some of them are more active than others, but together they make an invaluable part of our answer to the cancer problem. Of the 5,289 cancer cases admitted to our hospitals in 1947 about one half had contact with these clinics.

There are four Detection Centers now in regular operation in Hartford, New Haven, Meriden and Bridgeport. No two of these are exactly alike in their organization or procedure and they offer four interesting experimental projects in the detection field.

Cancer Information Centers are maintained by local branches of the Cancer Society in an increasing number of communities. At these the public is given information on the many popular questions about cancer and educational material is distributed. Through the centers, the Field Army and the Educational Committee of the State Cancer Society, the people are becoming wisely enlightened about cancer, many old fears are dispelled and an awareness of the importance of early diagnosis is being extended. It is the policy of the Information Centers to refer clients to private physicians.

The Tumor Clinics receive financial support from the Department of Health and the Cancer Society and the latter aids materially in the operation of the Detection and Information Centers. Assistance to all three of these activities will be increased when the now developing social service project of the State Cancer Society gets under way.

Nursing of terminal and convalescent cancer cases is a vital part of the whole cancer program and the Society has endeavored to meet the need usefully. On September 1, 1947 a nursing reimbursement plan went into effect, designed to pay for nursing visits to cancer patients who might not be able to afford this cost. In communities having a district nurse or nursing agencies these agencies are paid for services on a unit cost basis. During the first three months of operation of the plan, 38 agencies rendered this service and approximately 4,000 separate visits were made to nearly 500 cases. On March 1, 1948 the plan was extended to areas without district nurses and the local Field Army chairman may arrange for visits by nurses or trained attendants when requested or approved by the local physician.

Everyone agrees that research must always be an essential of a cancer program. Research depends upon two factors, competent investigators and financial support. Connecticut, for a small state, is unusually provided with able research people and because of that is fortunate in receiving generous grants. I have no knowledge of the amount of money from all sources for cancer research in

Connecticut, but this year the American Cancer Society has allotted $74,135 to cancer study in the State and fellowships amounting to $12,074, a total of $86,209. In addition the Connecticut Cancer Society has provided $18,600 for local research, making a total of $104,809 which is slightly less than one-third of all the funds raised in the annual campaign of the Cancer Society.

Appreciative reference should be made to the splendid work done by the Field Army in Connecticut in extending knowledge about cancer to our people and rendering understanding service. Because it is of popular rather than medical importance, I shall not go into the many details of its operation, but the Field Army is beyond praise and deserving of the highest tribute.

Connecticut may well be pleased with its facilities for cancer study and care and the generous support is all given by the people of the State, lay and professional alike, but there is much left to be done. The four groups involved, the Department of Health, the Medical Society, the Cancer Society, and the research group are vigorous and well informed. Working together they can follow a course to great human service and satisfaction to the medical profession. However, I am surely of the opinion that we need a unified command in the campaign against cancer in our State. Each of the forces concerned has a part to do and there should be no overlapping from one area into another, but we will go further and more steadily if there is acknowledged leadership. That leadership, I believe, should come from the State Medical Society for it is in the ideals and knowledge and honest conservatism of medicine that stable direction of this project is to be found.

CANCER OF THE SKIN

Jack Wolf, m.d., *New York City*

The Author. *Attending Dermatologist, New York Skin and Cancer Hospital*

First of all I should like to express to you my appreciation of the honor you have conferred on me by inviting me to take part in this your first State Cancer Conference and to address you on the *Diagnosis and Treatment of Cancer of the Skin*—indeed a considerable task to crowd into the confines of thirty minutes. I shall be forced to confine my remarks to the important features, the highlights of diagnosis and treatment and to stress these, omitting many of the significant details for another day.

First as to the classification of the cutaneous epitheliomas.

(A) Primary epitheliomas:

1. Benign
   - (a) Calcified epithelioma
   - (b) Sweat gland adenoma
   - (c) Sebaceous gland adenoma
2. Malignant
   - (a) Basal cell epithelioma
   - (b) Squamous cell epithelioma
   - (c) Mixed forms
   - (d) Malignant melanoma
   - (e) Atypical forms—precanceroses, Pagets disease, Bowen's disease, erythroplasia

(B) Secondary hematogenous and lymphogenous forms (metastatic):

The subject of discussion for today is the malignant epithelioma.

The basal cell epithelioma starts as a small glistening, waxy, slightly elevated and sharply circumscribed, firm, fleshy nodule. Fully 90 per cent of all basal cell epitheliomas occur on the upper two-thirds of the face with the eyelid regions and the nose as the most common sites involved. There is, however, no part of the cutaneous surface which may not be affected. As a rule the rate of growth is slow and it takes many months for a lesion to reach a diameter of 1 to 1.5 cm. As the lesion increases in size it may remain nodular for a time or it may leave a depressed, clear-looking center with an elevated, glistening, waxy, shiny border, often referred to as a "rolled" border; or, in the wake of the peripheral extension, a sclerotic, erythematous center with a barely visible elevated border may develop, a type referred to as the cicatricial basal cell epithelioma. The central scarring is not to be interpreted

as a sign of spontaneous healing; basal cell epithelioma may be demonstrated in the scarred site. Ramification of superficial, dilated blood vessels (telangiectasis) is a common finding in basal cell epitheliomas.

After 9 to 12 months these seemingly innocent lesions become centrally crusted and ulceration develops. The patient will complain of bleeding at the site when the crust comes away, only to be followed by the development of another crust and a repetition of the course. At times the epithelioma appears to have reached a quiescent stage since there is little sign of outward growth. This seeming inactivity is, in most instances, purely deceptive, since the process is invading and destroying tissue deeply and extending peripherally beneath normal-appearing epidermis.

If treatment is long neglected, as it is altogether too frequently because subjective symptoms are lacking, peripheral spread will lead to the formation of irregularly circinate and serpigenous lesions of varying depth and, ultimately, to the involvement of vital structures such as the eye. Extensive ulceration leads to invasion of bone and finally to death from meningitis, hemorrhage, or intercurrent infection directly attributable to the lesion. While basal cell epithelioma may cause extensive destruction as a result of local extension, it does not metastasize. Such extensive ulcerations may offer problems in clinical diagnosis, but even in these cases the border may be as revealing as in the small characteristic lesion recognized even by the notice. Histologic examination taken from the advancing margin quickly establishes a positive diagnosis.

There are other less common clinical forms of basal cell epithelioma. There is the pigmented basal cell epithelioma, usually a well circumscribed, more or less heavily pigmented, infiltrated, button-like lesion which on hasty examination may resemble a melanoma but which should offer little difficulty in differential diagnosis in most cases. Another and even more uncommon variant is the morphea-like epithelioma, a firm, hard, smooth, plaque-like lesion sometimes paler than the surrounding skin; the distinctly palpable border is rounded or scalloped and may not be sufficiently elevated to suggest the border of the basal cell epithelioma. Mucoid degeneration may produce a cystic type of lesion or even a soft, fleshy, hemorrhagic tumor.

While the clinical diagnosis of basal cell epithelioma in the more unusual appearing lesions may be entertained, microscopic examination is essential in order to substantiate what would otherwise remain as a clinical impression.

There is another less commonly encountered form of basal cell epithelioma in which multiple, small, coin-sized, red, scaly spots, rounded or oval, and reminiscent of psoriasis or of lupus erythematosus are disseminated over various parts of the trunk. Close inspection with a lens will usually reveal a very fine waxy and shiny characteristic border. Biopsy may, however, be required in order to establish the diagnosis. In superficial basal cell epitheliomatosis the face may be, and often is free from involvement but small papular lesions, histologically proven basal cell epithelioma, may be disseminated in profusion over the extremities as well as the trunk. In a considerable number of these patients there is a history of arsenical medication many years previously. Superficial epitheliomatosis of the trunk and/or the extremities and typical arsenical keratoses on the hands and feet may occur concomitantly, bringing added proof that arsenic, previously administered, is probably the culpable carcinogenic agent in a considerable number of patients with multiple superficial epitheliomatosis.

Basal cell epithelioma usually arises on normal skin but, as in squamous cell epithelioma, it may supervene on preexisting cutaneous changes as in radiodermatitis, xeroderma pigmentosum, on the pre-senile changes caused by exposure to the sun and wind, and other changes. Most patients present a single lesion, but multiple basal cell epitheliomas on various parts of the head and neck are not uncommon.

In addition to the basal cell epithelioma and the squamous cell epithelioma there is also the baso-squamous cell epithelioma. Of this latter variety there are two types: (1) the intermediate cell type in which the pathologic cell is neither typically basal nor prickle, but with characteristics intermediate between the two, and (2) the mixed type in which there is evidence of typical squamous cell radiodermatitis, xeroderma pigmentation, on the same section or in different parts of the same tumor. The diagnosis of baso-squamous cell epithelioma rests entirely on histologic grounds. The treatment, quite naturally, is governed by the more serious component, the squamous cell epithelioma.

Squamous cell epithelioma may arise de novo on apparently normal skin or mucous membrane but very frequently it arises on the basis of a pre-

existent lesion, the so-called precancerosis. From the pathologic point of view a lesion is or is not cancerous and there is some difficulty in justifying the concept of precancerosis. Clinically the concept is a valuable one. Cancer supervenes in certain cutaneous and mucous membrane lesions with great frequently, so much so that these lesions have been termed "obligatory precanceroses." These include:

(1) Xeroderma pigmentosum, a dystrophic dermatosis of familial occurrence which manifests itself in early childhood with large dark freckles and telangiectatic and atrophic spots. By the time the child is 10 years old keratoses and epithelioma have begun to appear. The course is a down-hill one. In only occasional instances, when the process is mild and the activity and the usual rate of speed of malignant transformation are much delayed, does the individual go on to adult life.

(2) Senile keratoses. These are brownish to brownish-black, dry, rough, hyperkeratotic, adherently-scaly spots on the exposed parts: face, ears, scalp and hands. Many of these go on to the development of squamous cell epithelioma. Senile keratoses should be destroyed early in the course of their development.

(3) Farmer's and Sailor's skin. The process here is essentially the same as in the senile keratosis, except for the fact that the eruption is more extensive, more severe and occurs in the pre-senile years, often even in early adult life. Farmer's and Sailor's skin is in essence a senile state of the skin, in the pre-senile years, in which the aging process is accelerated by exposure to the elements. Squamous cell epithelioma occurs early in the course of the well developed keratoses. These patients require careful periodic examination and treatment.

(4) Cutaneous horn. This hyperkeratotic lesion does, in fact, resemble a miniature horn in shape and cornification. Cutaneous horns of long standing, 3 to 5 years or more, frequently go on to the development of squamous cell epithelioma, the earliest changes appearing at the base.

(5) Radiodermatitis, that unfortunate sequel to excessive roentgen ray or radium therapy, in which epithelioma finally becomes engrafted on long-standing telangiectasis, atrophy, pigmentation and depigmentation of the skin. Basal and squamous cell epithelioma both complicate the picture of radiodermatitis. The greater the severity of the radiodermatitis, the greater the likelihood and the greater the frequency of squamous cell epithelioma.

(6) Leukoplakia. This term refers to the whitish or bluish-white spots on the tongue, buccal mucous membrane or vulva which, in a period of some few years, become verrucous and finally go on to the development of squamous cell epithelioma. Cessation of smoking is mandatory if the progress of the condition is to be arrested. Regression is the rule in early or even in moderately well developed leukoplakia when the irritating effects of tobacco are removed. Ill fitting dentures should be corrected and other sources of irritation also avoided. Careful periodic examination is required, as in all precanceroses, to note any change and to institute the proper treatment at the proper time.

(7) Arsenical keratoses. These are dry, slate-grey to black, rough, usually profuse, hyperkeratotic and verrucous, match-head sized spots disseminated over the fingers, hands, and soles, which may ultimately give rise to squamous cell epithelioma and to moist, red patches clinically suggestive of eczema but with the histologic picture of Bowen's disease.

(8) Bowen's disease. This is a rare dermatosis in which single or multiple, small, red, dry and faintly scaly spots may fuse to form plaques which eventually become red, moist, and occasionally verrucous. In many patients there is a history of arsenical therapy 10 or more years previously. The changes are usually confined to the epidermis for many years and deep invasion occurs rather late in the course. Bowen's disease may be looked upon from the very beginning as a chronic prickle cell epithelioma.

(9) Paget's Disease of the nipple. At the outset the red, raw looking surface resembles an eczematous dermatitis. It does not, however, respond to topical remedies and the process continues to spread, involving an increasingly larger area of the surface of the breast. Retraction of the nipple occurs late in the course of Paget's disease. Biopsy should be performed early, if anti-eczematous treatment proves to be of no avail, to allow for early diagnosis and prompt removal of the breast. Cancer cells may be demonstrated in the body of the breast even in some of the very early cases of Paget's disease of the nipple and some investigators are of the opinion that the process is always primary in the breast, involving the nipple region only secondarily. Extramammary Paget's disease is a rare occurrence and the diagnosis is usually made on histologic examination only.

(10) Erythroplasia. This term refers to a persistent, oozing dermatosis of unknown etiology

occurring almost always on the glans penis, occasionally also on the shaft and the scrotum, and more rarely in other locations. Erythroplasia is notoriously resistant to treatment. At the present time there is still considerable controversy as to whether the condition we call erythroplasia is the same condition so termed by the French. Cancer has not supervened in our cases; according to the French literature, cancer supervenes almost always in erythroplasia and they classify erythroplasia with the obligatory precanceroses.

Squamous cell epithelioma may also complicate the course of old scars, lupus vulgaris, lupus erythematosus, psoriasis, leg ulcers, sebaceous cysts, scleroderma, acrodermatitis chronica atrophicans, and occasionally other dermatoses.

A knowledge and understanding of precanceroses is a requisite for their proper management. The subject is a complex and difficult one, requiring not only thorough familiarity with diverse clinical pictures but also the ability to evaluate histopathologic findings. Proper surgical treatment of the early precancerous lesion will prevent the supervention of cancer and the possible loss of life from local extension of the cancer or from metastastatic invovlement of vital structures. The cure of the obligatory precancerosis affords the physician the unique opportunity of preventing the development of cancer.

Primary squamous cell epithelioma may appear on any part of the cutaneous surface or mucous membranes. The lip, oral mucosa, glans, prepuce, labia and anal region are favored sites. On the skin it begins as a small, hard, red nodule which gradually increases in size and finally, after a period of several months and occasionally longer, goes on to ulceration. The clinical picture is a varied one: during the early phase the lesion may be indistinguishable from a basal cell epithelioma or from other nodular lesions; during the ulcerative and vegetative phases the diagnoses of syphilis, tuberculosis, deep mycotic infection, bromoderma, as well as ulceration from other sources, may have to be excluded. If untreated the ulcer will increase in extent; large papillomatosus and fungating masses may develop.

Primary squamous cell epithelioma of the mucous membranes appears first in the form of a small area of induration, a small nodule or a small warty lesion. If allowed to go untreated or if inadequately treated the zone of induration gradually increases in extent and finally ulceration develops. Metastasis to the lymph nodes occurs relatively early in the course of mucous membrane epithelioma.

On the lip squamous cell epithelioma is often preceded for a period of years by slight but persistent scaling along the vermilion border of the lip. Ultimately thickening of the body of the lip takes place and frank malignancy is present. Antecedent scaling is, however, not a requisite; a zone of induration, or a small nodule or warty lesion may appear very suddenly along the border of the lower lip. While cancer of the lip occurs chiefly during middle life and the years beyond, predominately in the male, the possibility, even probability, that induration of the lower lip in young male adults, and also occasionally in women, signifies cancer is often overlooked and much valuable time often lost. Lymph gland involvement occurs earlier in the ulcerative type of lesion than in the hypertrophic verrucous type of lesion. The less differentiated the cell, the more rapid the spread and the earlier the metastasis to lymph glands and to other locations. Cancer of the upper lip is uncommon; when it does occur it may be the result of downward extension from a lesion on the cutaneous aspect of the lip.

A word about melanocarcinoma. These highly malignant lesions frequently arise on the basis of a pigmented mole which had shown no essential change during a period of many years, or they may arise in what was previously normal looking skin. The extremities are the commonest sites for malanocarcinoma, especially the areas around the toe and finger nails, not infrequently the subungual region. However, melanocarcinoma may develop at any site. Pigmented moles which suddenly take on the power of growth, become indurated at the base, bleed or become crusted should be widely excised.* Unfortunately even many of the very early lesions have metastasized by the time the patient has presented himself for treatment. Excision must be wide, going at least an inch beyond the edge of the lesion. On the extremities early amputation of the involved digit is the treatment of choice. Time does not permit more extensive discussion of other aspects of the treatment: site of amputation, x-ray therapy to the glands, dissection of the regional glands, etc.

*Contrary to previous thought on the subject, many physicians are of the opinion today that biopsy is not contraindicated in suspicious melanotic lesions. On the basis of histologic examination more or less radical treatment may be indicated.

In the final analysis the diagnosis of malignant epithelioma depends on experience: i.e., the seasoned ability to make a clinical diagnosis on clinical examination or by biopsy and microscopic study of the section. Lacking this seasoned ability the physician requires a *sense of awareness* of the possibility that a cutaneous tumor or ulceration may be a cancer. Once that possibility is entertained, the necessary measures required to arrive at a diagnosis may then be taken.

For purposes of record, and possibly for the future management of the case, it is advisable to confirm the clinical diagnosis by histologic examination unless there is some very valid objection to the removal of a piece of tissue prior to radiation therapy. In patients treated by surgical means sufficient tissue is always available for histologic study. In small lesions it is preferable to do an "excision biopsy," rather than to attempt to remove a tiny piece for histologic examination and then to remove the rest of the lesion after the histologic report has been rendered.

TREATMENT*

There is no single best method of treating cancer of the skin. Experience with a particular modality and using it to its fullest advantage is what is likely to determine the choice of the particular modality. Excellent results are obtained with radiation therapy and with surgery. The preference for x-rays or radium, and to a degree the dosage, as well as the selection of the particular surgical means of destruction is also largely an individual matter depending on the familiarity of physician with the specific technic. Combined surgical and radiologic skill of course affords the physician far greater flexibility in the selection of the method which will not only cure but will produce the best cosmetic end-result. Consultation and team-work are often essential in determining the best procedure in a given case. While the cure of the cancer is the primary aim the importance of a satisfactory cosmetic end-result on exposed surfaces should not be overlooked nor should its importance be underestimated. Select the method which will not only cure but will give the best cosmetic result.

Many physicians, a group in which I include myself, prefer surgical removal wherever and whenever possible, especially in the treatment of the basal cell epithelioma, reserving x-ray therapy for lesions on the tip of the nose, for the treatment of cancer in the aged, and also for the infiltrating type of embryonal, "juicy-celled," squamous cell epithelioma. Whenever the lesion lends itself well to excision, especially where the line of suture follows along a normal fold in the skin, excision is the ideal method of removal. In the epithelioma age group the laxness of the skin and the frequent location in the region of the lower lid allows for the frequent use of this method of treatment. Excision of lesions on the trunk and extremities is almost always feasible and avoids the sequelae of roentgen and radium therapy, even in lesions of limited extent and severity. Lesions that do not lend themselves well to excision may be destroyed by electrodesiccation, electrocoagulation, or by means of curettage with the sharp dermal curet followed, if necessary, by electrodesiccation or by the application of caustic agents such as the acid nitrate of mercury. The latter technic was introduced by Sherwell and is referred to by his name; it is a very good method of treatment. The sensation imparted by the curettage of pathologic tissue is quite different from that experienced in curetting normal tissue. The experienced finger can readily detect the difference in sensation between normal and abnormal tissue and when the epithelioma has been removed the additional use of the acid nitrate of mercury or of desiccation imparts an added feeling of security; but if curettage is sufficiently thorough it is questionable whether additional cauterization is necessary. If the acid nitrate of mercury is used, neutralization of the excess acid, after some 5 minutes, by the application of powdered bicarbonate of soda is advisable. The healing time is prolonged to some 6 weeks as a result of the additional cauterization, but this is a small price to pay for the added safety factor, especially in those cases where there is doubt as to whether the curet removed every vestige of epithelioma.

Some physicians advocate combined surgery and x-ray therapy. There are two schools of thought on this subject and I belong to that school which feels that adequate surgery precludes the necessity for radiation therapy. On the other hand, if a cancericidal dose of x-rays is to be given to any cutaneous lesion, previous surgical removal is not necessary. The essential point is that the two forms of treatment are not complementary. If x-ray therapy is given because there is some doubt as to whether

*The remarks in regard to treatment will be limited to the uncomplicated lesion in which there is no evidence of metastasis.

surgical treatment was adequate, a cancericidal dose must be given; nothing less than that can be logically considered adequate therapy.

The ideal time to destroy an epithelioma is the very first time it is treated. Adequate treatment will cure almost all of the early cases and a large majority of the other. Inadequate treatment leads to clinical activity within a relatively short time and experienc has taught us that the failure rate is far higher in th treatment of recurrent lesions than in previousl untreated lesions. The physician who first treats th patient bears a great responsibility for effecting permanent cure at the very outset in uncomplicate lesions in which cure is to be expected.

CANCER OF THE BREAST

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THE breast is the most common site of cancer. According to Haagensen[1] it is twice as frequent as any other type of cancer in women, and about 4 per cent of all adult women contract the disease. Moreover, if cancer of the breast is diagnosed early, which means before there is evidence of metastases, 75 to 85 per cent of those properly treated will be well and free from evidence of disease in 5 years. If, on the other hand, the diagnosis is made late or if the treatment is poor, the results will be poor and not more than 25 to 30 per cent of these patients will be alive and well after 5 years have elapsed.

There is, then, a truly great incentive to early diagnosis and early treatment.

Fortunately cancer of the breast is accessible. It is accessible to you and to me as doctors, and it is accessible to the patient. Moreover, it is accessible from the point of view of treatment. We have, then, the most common of all cancer so situated that it will usually be noted early by the patient, and it is so located that you and I as physicians can and should make an early diagnosis; and where we can cure most patients who come to us, if the over-all job is well done. On the other hand, if the patient fails, or we fail, then the results are pitifully poor.

How then can this problem be best approached? First and foremost, it is to create throughout the public at large, an understanding of the importance of this problem and the need for early medical consultation. Next, there must be available to all patients, regardless of their financial status, facilities for early diagnosis and for prompt and proper treat ment. I think I can say with assurance that you State particularly has done these two jobs well.

Now comes the last and probably most importan and is that which brings me here today. The momen you and I as physicians create interest on the part o the patient and help to set up the facilities whereb care can be given for all, then we accept a truly great responsibility, and the fulfillment of tha responsibility means a continuing educational pro gram. I don't mean for the education of the physi cian who is practising in a small rural area; th education I speak about goes from the bottom righ to the top. I refer to a pooling of experiences; th utilization and spreading of all of the informatio that we can have about this disease so that not only will we become more and more skilled in our ability to accept this responsibility, but also there will b instilled in every doctor in this and in every state true appreciation of the importance of thinking o cancer. As my former chief, the late Dr. D. F. Jones used to say, "Now, doctor, if you don't look for four-leaf clover, you're never going to find one." And if, when you examine a patient, you don' think of cancer and look for cancer, you're no going to find it.

So much for the background. Now to get dow to something more concrete. Cancer knows no age I have seen too many young poeple denied th chance to live because they were not in the cance age. We make a diagnosis of cancer on a basis o symptoms, not on a basis of age, and I beg of you t think of cancer in terms of symptoms or signs n matter what the age of the patient. We don't thin statistics when we see an individual patient in ou office. We think of that individual and no one indi

dual fits into any statistical pattern. Until we iminate thinking in terms of a cancer age, we are ›ing to miss a good many of the younger people. efore leaving this question of age, I just might mind you that over a 10-year period somewhere ound 5 per cent of the cancer in your own state as in patients between the ages of 10 and 19.

What symptoms bring patients with lesions of the reast into your office and mine? Not putting these easons in order, either of frequency or importance, ey will come with one of 5 complaints. Pain in the reast, a lump, discharge from the nipple, a sore eeping eczema-like area around the nipple, or a ange in the contour or appearance of the breast, rticularly retraction of the nipple.

AIN

Probably most patients that I see in my office me because of pain. For some reason pain in the reast, particularly when it persists or recurs, and pecially if some friend or relative has recently died cancer, brings the patient rather promptly to the ffice, sometimes more promptly than finding a ump. With few exceptions, pain is not an early mptom of cancer of the breast. While in most stances, the patient whose presenting symptom is ain will be found not to have cancer, I have re-ently seen two patients, each of whose presenting mptom was pain, and each of whom had a very pidly growing cancer of the breast. The painful reast may or may not be associated with a palpable ass.

UMPS

The patient who comes into the office with a lump her breast presents a much more serious and ifficult problem than the patient with pain and no ump. A single painless lump in a woman's breast cancer until proven otherwise. Without question e patient who discovers a completely symptom-ss lump in her breast has an excellent chance of aving a malignant tumor. The chances of it being alignant are increased if it is a single tumor; hether or not it is malignant may be determined pon physical examination if the findings are char-teristic, but frequently a definite diagnosis will be npossible except by means of examination under e microscope.

ISCHARGE FROM THE NIPPLE

Discharge from the nipple may be clear, cloudy r bloody. Almost without exception, it means the resence of a cyst or dilated duct in direct communication with the main duct. If the discharge is not bloody, and particularly if there is no tumor to be found, there is little chance of that lesion being malignant. If, on the other hand, the discharge is bloody, then in all probability that patient has an intraductal papilloma which, in the absence of a palpable tumor, is usually benign. If a palpable tumor is present, then the chance of a malignant lesion are greater. I do not believe that operation is essential for the patient with a clear discharge and no palpable tumor. If the discharge is bloody, then I believe that the responsible lesion should be excised and carefully examined under the microscope, being prepared to do a more complete operation if any evidence of malignancy is found.

ULCERATION AROUND NIPPLE

The so-called eczema of the nipple or Paget's disease of the nipple is a most interesting lesion. Until proven otherwise by careful examination of the amputated breast, it should be assumed that there is a carcinoma within the breast. The skin lesion itself is not the malignant lesion. The malignant lesion can usually be palpable within the breast tissue, but frequently cannot be palpated by the examining fingers. Nevertheless, the superficial ulcerating, red areola so characteristic of this disease is an indication for amputation of the breast and careful examination of that breast by the pathologist even though no tumor can be felt in the breast. Removal of the pectoral muscles and axillary contents must be promptly carried out if cancer is found.

RETRACTION OF NIPPLE AND ALTERATION OF APPEARANCE OF BREAST

Not infrequently, some alteration in the normal contour of the breast will be the first thing noticed by the patient. Any alteration of this kind must be accepted as due to an underlying cancer unless proven otherwise. A very careful examination will usually reveal an underlying tumor, and the combination of tumor and retraction means cancer.

EXAMINATION

Before discussing the details of examination of the breast it is important to stress the basic factors upon which clinical diagnosis of cancer is made. In general a clinical diagnosis of cancer is made because a cancer is not an encapsulated tumor, because it is usually firm, and most important because of the tendency of the surrounding structures to retract probably due to the shortening of fibrous strands

which extend out from the tumor itself. This retraction which extends through to the overlying skin probably is the most important single physical phenomenon which is found; and when it can be clearly demonstrated, is usually pathognomonic of an underlying cancer. With this in mind our examination is based on obtaining three important findings: 1. the presence or absence of a tumor; 2. the presence or absence of adherence of the overlying skin to that tumor; 3. the presence or absence of enlarged axillary or supraclavicular nodes.

The most important single factor in making a clinical diagnosis of cancer of the breast is the development of a routine of examination which will enable the careful examiner to elicit those signs from which we make the diagnosis of cancer of the breast. The most important of these is dimpling of the overlying skin. I don't care how experienced you are nor how skilled you are, unless you spend time, give thought, and concentrate on what you are doing when you examine a patient under suspicion of having cancer, you are not going to get all of the information that is available to you. Each examiner will probably work out a routine from which he can get the most information in the easiest way. That which is most effective for me can be briefly outlined as follows:

The patient is seated at the end of the examining table, bared to the waist. The contour of the breasts is examined carefully in good light. One breast will frequently be a little larger than the other and of this the patient is frequently aware. Any alterations in the normal contour are noted. The patient is then asked to raise both arms slowly from the side until they are well above the head. Careful note is taken of any changes that may occur in the contours previously noted. A slight depression may signify the presence of an underlying tumor. Not infrequently the breast which feels normal with the arms at the side shows definite evidence of a flattening or depression with the arms above the head, bringing attention to the site of a lesion. After this manipulation, the arms are again allowed to hang normally by the side, the breasts are carefully palpated. If any tumor can be palpated, an effort is made to demonstrate any suggestion of adherence of the overlying skin. Following this, with the arms hanging loosely by the side and the pectoral muscles relaxed, each axilla is very gently palpated, the left axilla with the right hand, sometimes exerting pressure in the intraclavicular area with the opposite hand. The size and consistency of the lymph nodes are carefully noted. Either prior to examination of the axilla or following it, the supraclavicular area on either side is carefully palpated.

After examination in the sitting position, the patient then lies on her back with the arms by the side. It is in this position that a tumor of the breast is felt more easily. The breast will be more flattened out against the chest wall and by careful palpation of the breast against the thoracic cage even a small tumor can usually be found. If a tumor is felt in this position which could not be felt with the patient sitting, every effort is again made to demonstrate whether or no there is any dimpling of the overlying skin. If it cannot be demonstrated with the patient lying down, the patient is again put in the sitting position with definite knowledge of the location of the tumor and all manipulations gone through again to bring out all possible information. But even with all of this, many times it will be impossible to demonstrate any fixation of the tumor to the overlying structure.

DIAGNOSIS

Diagnosis of late cancer of the breast is very easy and need not be considered here. Our emphasis is in early cancer because it is in early cancer, diagnosed early and properly treated, that our best results will come. If a definite tumor is found, and if it can be demonstrated beyond question of a doubt that this tumor is adherent to the overlying skin, the diagnosis in all probability is cancer. Fat necrosis may simulate this diagnosis and defy accurate differentiation. Quite frequently, the history of previous trauma will be absent and diagnosis can only be made after exploration of the tumor.

It may surprise you to know that a condition not infrequently diagnosed as cancer on clinical findings is chronic breast abscess. I have seen a radical amputation of the breast done by an experienced cancer specialist upon a clinical diagnosis of cancer only to find a chronic abscess with no evidence of malignancy in the breast. In fact, I saw this very operation done before a large surgical gathering in one of our large well known hospitals not too many years ago.

This brings us to the question of surgical biopsy. How often should it be done and under what conditions should it be done? I know of no objection to a surgical biopsy done on the operating table with all preparation made to do a complete amputation

of the breast and dissection of the axilla if immediate examination of a frozen section shows carcinoma. I am distressed to see how frequently doctors still remove a small breast tumor from a woman, send it to a laboratory to have it examined and delay definitive treatment to some later time. Within a month I had two patients in the hospital at the same time, both of whose privilege to live had been lessened because some doctor had removed a small tumor and then sent the specimen to a laboratory where a diagnosis of cancer was made. In one instance, the mistake having been made, the doctor decided to follow it by x-ray treatment because they didn't want to go back and complete the operation. Only because this woman had a brother-in-law who is a doctor was the proper operation finally carried out. Whether she is cured or not I do not know, because at the time of her radical procedure the disease had already metastasized to some of the axillary nodes. Without question both of these women and many others with similar circumstances have had the opportunity of living lessened because of the improper manipulation. Unless you have the facilities to do a complete operation without delay, never yield to the temptation to remove what looks like a simple tumor from a woman's breast. If you do not have those facilities, there will be some place, not too far away, where the facilities will be available for proper treatment.

There is one more word I should like to add about diagnosis and that is this. It is my policy never to discharge a patient on one examination. Every patient, who comes, or is sent to me, because of some symptom or suspicion of a breast lesion, must return for subsequent examination after an interval varying from three weeks to two months because I do not believe that any of us are in a position to give a patient a clean bill of health by a single examination if a given breast is under suspicion.

TREATMENT

Time does not permit nor is this the proper occasion to go into details of treatment. Operation, after a positive diagnosis which consists of removal of the breast with a wide margin of normal skin, both pectoral muscles and the axillary contents, gives the patient with cancer the best chance of a permanent and complete cure. There is no compromise on this procedure if it is the intent of the operator to give the patient the best that he has to offer. Anything less is a compromise, and it does not pay to compromise with cancer.

I should like to make one more point; that is in relation to the other breast. For some years now I have taken a definite policy regarding the other breast. These patients will all be followed at varying intervals for an indefinite period of time. If a tumor, even though it has all of the characteristics of a benign cyst or area of mastitis, develops in the other breast, it is my policy to do a simple amputation of that breast rather than to do a local excision of the tumor. The breast is immediately examined by the pathologist so that a more complete operation can be done if cancer is found. I do this for two reasons. In the first place, there is a definite incidence of cancer of the other breast. I can't tell you exactly what it is, but I am certain that it is at least 5 to 10 per cent; and removal of that breast is, therefore, excellent prevention against the development of this second cancer. Moreover, the mental relief, particularly in young people who have lost one breast from cancer, is much greater than I had imagined possible. Increasing experience with this concept of the other breast has only served to increase my conviction that it is sound treatment.

In closing let me repeat that our responsibility in cancer of the breast is unusually great. It is the most common type of cancer; it is accessible for diagnosis and for proper treatment; and, if we make an early diagnosis and follow through with proper treatment, most of these women will be cured of their cancer.

BIBLIOGRAPHY

1. Haagensen, C. D.: Journal of the American Medical Association, 1948, Vol. 138, page 195.

CANCER OF THE ORAL CAVITY

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I. THE PROBLEM

The relative importance of cancer of the mouth and lip is indicated by the fact that it accounts for approximately three per cent of all cancer deaths and it is estimated that this year approximately 5,500 persons in the United States will die from cancer arising in this region. Connecticut now has about 225 new patients each year with cancer of the oral cavity. It is the purpose of this paper to discuss this problem as it now exists and the potentialities of the medical profession in reducing the death toll from this disease.

a. *Cancer Detection.*

The recent emphasis on detection of early cancer and precancerous lesions directs attention to cancer arising in those parts of the body which are accessible to physical examination. Cancer of the oral cavity with few exceptions is potentially capable of being diagnosed in an early and curable stage of the disease. In addition, since this anatomical region is readily accessible, we have a unique opportunity for the observation and correction of precancerous lesions.

The scope of such a program of preventive medicine and the time and labor involved in bi-annual physical examination emphasizes the need for an appreciation of the incidence and distribution of the disease. Cancer of the oral cavity is more common in men and accounts for 5.2 per cent of the cancer deaths in the male and 1.2 per cent of the female cancer deaths. From the standpoint of cancer detection, however, it is of even more importance in the male since cancer of the oral cavity accounts for 36 per cent of the deaths and 31 per cent of the incidence due to cancer arising in an accessible anatomical region in men. In women it accounts for only 2.6 per cent of the deaths and 2.2 per cent of the incidence due to cancer arising in an accessible anatomical region. A recent survey in Connecticut indicates that 85.5 per cent of cancer of the oral cavity and lip is found in men. If a program of cancer detection is to be instituted on a sound economic basis these facts deserve consideration.

Table I

CANCER ACCESSIBLE TO PHYSICAL EXAMINATION

	PER CENT TOTAL CANCER MALE		PER CENT TOTAL CANCER FEMALE	
	*U. S.	CONN.†	U. S.	CONN.
Lip and oral cavity	5.2	8.5	1.2	1.2
Skin	2.5	12.0	1.5	7.3
Rectum	6.5	6.6	4.5	3.9
Breast	—	0.4	18.2	23.9
Uterus	—	—	19.3	18.8
Total accessible cancer	14.2	27.5	44.7	55.2

*Based on cancer deaths—U. S.
†Based on cancer incidence—Conn. (37,846 patients)

b. *Prognosis.*

Cancer of the mouth and lip is also of importance because of the potential high curability if it is detected early and treated promptly and adequately. There are few studies available to indicate the average results obtained when the average patient is treated in the average hospital. The five year survivals over a seven year period for 29 general hospitals in Connecticut are shown in Table II. These figures are below the average reported in the literature from more specialized clinics. The results reported from the more specialized clinics indicate that the cure rate might be more than doubled by earlier recognition and treatment of the disease. While it is recognized that the prognosis in cancer of the mouth is dependent on many factors, a survey of the literature appears to justify the classification in Table II. The most important factor in prognosis is the presence or absence of metastasis in the regional lymph nodes. The time between the onset of the primary cancer and the metastasis to the lymph nodes varies according to the anatomical location of the cancer, the pathological grade, and the biological characteristics of the tumor. The most important factor in the presence or absence of metastasis and the only one over which we may exert control is the time since the onset of the cancer. It has been demonstrated that the pathological grade of the

tumor, as well as its biological characteristics, may change with the passing of time. It is for these reasons that the statement has been made that the life of the cancer patient is in the hands of the first physician who sees him.

Table II

CANCER OF THE ORAL CAVITY

SITE	INCIDENCE IN CONN. PER CENT	CURABILITY EARLY PER CENT	CURABILITY LATE PER CENT	CURABILITY AVERAGE PER CENT	CONN. PER CENT
Lip	42.2	90	40 - 30	70	60.0
Cheek	3.2	75	10 - 5	30	16.6
Tongue	23.8	70 - 50	15 - 2	25	15.5
Gingiva	4.0	65	15 - 3	25	21.7
Floor of mouth	8.8	60	15 - 2	25	18.0
Palate	5.6	60	15 - 0	30	28.1
Tonsils	12.3	40	8 - 0	18	11.4

Early—Stage I, no metastasis
Late—State II, III, IV, with metastasis

The anatomical location of the cancer not only influences the early symptomatology, and consequently the early recognition and diagnosis, but also the biological characteristics of the tumor. For example, it has been clearly demonstrated that cancer of the lip has different biological characteristics than cancer of the tongue or tonsil, as shown by the rate of growth. Furthermore, there is evidence that the mobility of the part may play a role in shortening the time interval when embolic metastasis to the lymph nodes may occur as Taylor has shown in Table III.

Table III

TIME OF APPEARANCE OF METASTASIS AFTER ONSET OF PRIMARY CANCER

LOCATION	PER CENT WITHIN 6 MONTHS	PER CENT WITHIN 1 YEAR
Lip	10	37
Buccal mucosa	50	75
Tongue	65	90

The anatomical site also influences the prognosis because it may limit the type of therapy which is available as well as determine which lymph nodes are involved and the complications due to involvement of adjacent structures. The grade of the primary tumor also influences the prognosis chiefly because the more malignant grades are prone to metastasize earlier and more often.

In summary the prognosis is determined by:

(1) The anatomical site of origin.

(3) The pathological grade.

(3) The time interval from onset to treatment.

(4) The presence or absence of metastasis to lymph nodes. The most important factor is the presence or absence of lymph node metastasis which can be controlled only by shortening the time interval from the onset of cancer to treatment.

II. ETIOLOGY AND PREVENTION

Our knowledge of the etiology and prevention of cancer has accumulatd slowly over the years and is still fragmentary. While we are not yet in a position to practice highly effective cancer prevention, we nevertheless possess enough information if it is properly applied to materially decrease the death toll from this disease. The oral cavity because of its accessibility presents a unique opportunity for the study of the factors which may be involved in the etiology and prevention of cancer.

There is a great need for more precise study of the incidence of cancer and the many factors which may be involved in the etiology of the disease. The sex incidence of cancer of the oral cavity as reported in 29 general hospitals in Connecticut is shown in Table IV.

Table IV

CANCER DISTRIBUTION
29 GENERAL HOSPITALS IN CONNECTICUT
1935 - 1946

SITE	NUMBER	PER CENT TOTAL CANCER	RATIO M	RATIO F
Floor mouth	86	0.2	42.0	1
Lip	596	1.7	10.5	1
Tongue	292	0.8	6.1	1
Gum	44	0.1	4.5	1
Pharyngeal	71	0.2	4.4	1
Tonsil	125	0.4	3.6	1
Mouth general	187	0.5	3.5	1
Nasal pharynx	48	0.1	3.4	1
Palate	77	0.2	2.7	1
Nasal cavity	19	0.1	2.2	1
Mucosa cheek	47	0.1	2.1	1
Skin	2504	7.0	1.4	1
Oral cavity exclusive of lip	929	2.6	4.5	1

Cancer incidence in relation to sex and economic status as found in the New Haven Hospital is shown in Table V.

TABLE V

CANCER INCIDENCE ACCORDING TO SEX AND ECONOMIC STATUS
NEW HAVEN HOSPITAL
860 Patients

	RATIO	
	MALE TO FEMALE	WARD TO PRIVATE
Lip	48.0 - 1	4.4 - 1
Oral cavity	8.0 - 1	5.8 - 1
Esophagus	6.3 - 1	6.3 - 1
Stomach	2.1 - 1	6.0 - 1
Colon	1.0 - 1	2.0 - 1
Skin	2.2 - 1	1.4 - 1
Larynx	6.5 - 1	2.0 - 1
Lung	5.5 - 1	6.2 - 1
Breast		1.1 - 1
Total admission over age 35	1.0 - 1	1.0 - 1

These studies and others reported in the literature indicate an etiological factor in cancer of the oral cavity and lip more commonly found in the male. The New Haven Hospital study in common with those reported by Kennaway in England indicate an etiological factor more frequently found in those of a lower economic status. Since breast cancer which is caused by factors of internal origin does not show a difference according to economic status, it appears that the etiological factor in oral cancer is of external origin. Thus we have an etiological factor more frequently found in the male of lower economic status and diminishing in effect from the mouth downward.

It has been suggested that bad oral hygiene with chronic dental infection in the form of caries, pyorrhea, and gingivitis may continually feed an etiological agent into the mouth and upper gastro-intestinal tract. It is also possible that dietary deficiencies may be responsible for both the chronic mouth infection and cancer. More precise studies are needed to elucidate this point.

TABLE VI

ORAL HYGIENE AND CANCER

CONDITION OF TEETH	PER CENT PRIMARY ADMISSION	PER CENT FIVE YEAR SURVIVAL	PER CENT FAILURE
Good	2	13	0
Fair	8	19	5
Poor	56	25	63
Edentulous	32	43	29
Complete false dentures	2	0	3

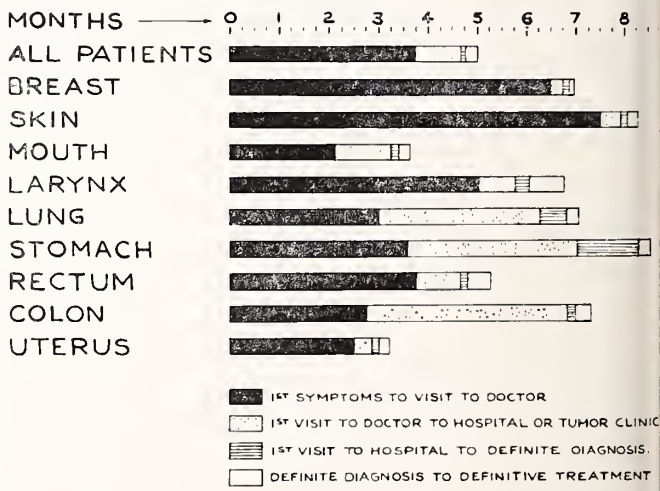
Dental defects such as sharp, jagged or missing teeth resulting in chronic trauma of the mucous membranes have also been shown to be etiological factors and require correction.

Cancer of the oral cavity is also frequently associated with areas of leukoplakia, the etiology of which is unknown. Such areas require frequent observation and may be treated by electrocoagulation or excision. Chronic glossitis and atrophy of the papillae are frequently present suggesting dietary deficiencies. Syphilis is undoubtedly an etiological factor, especially in cancer of the tongue.

Tobacco as a cause of oral cancer has been a subject of much controversy. It appears that excessive use of tobacco is an etiologic factor in some people, both as a cause of cancer and a cause of leukoplakia; however, there is no conclusive evidence which will warrant a generalization as to the role of tobacco as an etiologic agent in oral cancer. More precise study of this problem is needed.

III. RECOGNITION AND DIAGNOSIS

The most important step in saving the lives of those afflicted with cancer of the oral cavity is to treat the disease adequately before it has metastasized to the lymph nodes. With the exception of the lip, cancer of the oral cavity tends to metastasize early; hence any delay on the part of the patient or the physician may prove fatal.



MEDIAN DELAY TIME INTERVALS

FIGURE 1

The median delay in the treatment of these cancers averages between thee and four months. More than half of this delay is caused by failure of the patient to consult a physician when the lesion is first noted. This can be corrected only by more intensive

education of the lay public in which each physician has a responsibility. The first step in early recognition is to make every person aware of the potentialities of cancer and the need to consult a physician promptly. The second most important step is to make every physician alert to the potentialities of oral cancer and the need for immediate biopsy and consultation when in doubt. The tendency of cancer of the oral cavity to metastasize early makes it imperative that the diagnosis and treatment be rendered promptly.

The symptoms of an early cancer of the oral cavity are so slight and so variable as to make a description of little significance. The important fact is to be constantly alert to the suspicion of cancer.

Cancer in the posterior part of the mouth or hypopharynx may not give symptoms until the growth is well advanced. Early symptoms when they occur are usually mild, such as a "sticking" sensation. In the early stage the growth may be difficult to find, and require repeated examination. If indirect examination with a mirror is unsuccessful in a patient suspected to have a tumor, direct laryngoscopic examination is indicated. Characteristically early cancer is a small painless indurated area only a few millimeters in diameter. Later there may be ulceration, a growth, and pain due to infection. Examination should include a thorough inspection of the entire oral cavity with the aid of a good headlight or mirror. Every physician should be competent in the use of the laryngeal mirror to visualize the hypopharynx. Suspicious areas should be palpated and the presence and size of palpable nodes recorded. The absence of enlarged nodes has no significance in the diagnosis of cancer. Their presence may mean cancer or infection. An enlarged lymph node, however, may be the first evidence of cancer, especially those arising in the hypopharyngeal region. If a doubtful lesion is found in the oral cavity, immediate biopsy or consultation is indicated. The worst advice that can be given is to advise the patient to forget about it, and the most costly error is to watch the lesion grow. There is far less risk to the patient to perform a biopsy on an infected or syphilitic ulcer than there is to let a suspicious lesion go undiagnosed. Certain cancers arising around the roots of teeth require a high degree of cancer suspicion and they are not infrequently treated conservatively for long periods before a biopsy is done. Some of the benign lesions which occur in the mouth may be listed, such as calculus of glands, ranula, hemangioma, lymphangioma, mucous cysts, herpetic ulcerations, and ulcers due to avitaminosis, infection, and syphilis. Usually their diagnosis is obvious, but when in doubt a biopsy or consultation is indicated.

IV. TREATMENT

Cancer of the oral cavity is not a common disease and the methods of treatment are not well established standardized procedures. This is particularly true of the rarer forms of the disease when the experience of any one individual is necessarily limited and where a background of experience in the management of the disease is essential to sound judgment. For these reasons the subject deserves special attention by surgeons with special training in the potentialities and use of x-ray and radium, or as a group effort between the various specialists. In general, those physicians having the widest experience in the treatment of the disease tend to a more optimistic outlook and a keener appreciation of the requirements and potentialities of radical treatment.

It is not within the scope of this paper to encompass the details of the various therapeutic procedures required to deal effectively with the many types of cancer encountered in the oral cavity, but rather to discuss the general principles involved.

The treatment of cancer of the oral cavity requires a plan of action according to whether the objective to be achieved is the total cure of the cancer or merely palliation. When in doubt as to the outcome it is better to plan curative treatment since unexpected good results may be obtained in what may appear to be a hopeless situation.

In planning the cure of oral cancer due consideration must be given to (1) the control of the primary tumor, (2) the control of the lymph nodes in the drainage area, and (3) the general physical condition of the patient required to withstand radical treatment. The timing of the various procedures is of the utmost importance since if metastasis has not already occurred, it may take place at any time; or if the tumor is already growing in the proximal nodes, it may spread to adjacent areas.

V. CONTROL OF THE PRIMARY CANCER

The location, grade, size, and duration of the primary cancer are all factors to be considered in estimating whether the primary tumor can be controlled. When radiation must be relied on to control the primary tumor, however, the result cannot be

predicted with accuracy because of the unknown factors in the host-tumor relationship. Only a trial of radiation will prove a given tumor in a given patient radio sensitive. Consequently, if metastasis has not occurred, it is wiser to await the results of the attempt to control the primary cancer as there is little use in removing the regional lymph nodes if the primary cancer cannot be controlled. If the tumor is rapidly growing and if metastasis to the proximal nodes has already occurred and it appears likely that the primary tumor can be controlled, it may be necessary to hasten the treatment of the regional nodes without waiting for a final result on the primary cancer.

The methods most successfully used in treating primary cancer of the oral cavity and lip vary according to the location, size of the tumor, and the structures involved. The methods available are radiation either by x-ray or radium or in combination, and surgical removal or destruction by electrocoagulation or cautery. The essential of whatever method is used is that all of the tumor must be removed or destroyed.

Radiation treatment by means of x-ray or radium was thought to hold great promise in the treatment of oral cancer. While it is still the best method of treatment for many cancers, its limitations and uncertainties have become more apparent. The chief obstacle to the success of radiation therapy has been the inability to predict with certainty the response of a given tumor to radiation. A great step forward has been the use of the intraoral cone limiting the beam and permitting more intensive radiation to a given area. However, this technique introduced a new risk comparable to surgical removal, namely, the danger of not treating the whole tumor. A knowledge of anatomy in directing a radiation beam is just as important as the anatomical removal by surgery and failure to include the whole tumor in the beam undoubtedly accounts for some of the poor results, the damage to surrounding structures, especially bone, also limits radiation therapy.

As the limitations of radiation therapy have become better recognized there has been a tendency to revert to surgery in the treatment of oral cancer whenever the lesion is so located and of such size as to make this possible. When bone is involved, surgical removal offers more hope for cure than radiation. Surgery may be contraindicated because the location and size of the tumor makes successful removal unlikely or because of resulting deformity as in the floor of the mouth.

In order to deal most effectively with oral cancer the therapist should have a thorough knowledge of the potentialities and liabilities of all forms of therapy. Occasionally all may be required in the same patient.

The first step in the treatment of oral cancer is to correct defective oral hygiene and to institute a program to improve the general physical condition of the patient. Wounds of the oral cavity, whether caused by surgery or by radiation, are prone to infection and one of the most difficult problems in wound healing are in those tissues injured by radiation therapy.

Cancer of the buccal mucosa has been effectively treated by a variety of methods depending on the size and location of the primary lesions which are the chief factors in determining the curability. Cancers in the posterior tongue behind the circumvallate papillae are not accessible to surgery, tend to matastasize early, and have a prognosis less than one-quarter as good as the anterior third. It is treated by external radiation and radium. Surgery may be used in the tongue whenever the lesion is small and accessible. Elsewhere intra-oral roentgen radiation supplemented by radium or the use of radium needles is indicated.

The treatment of the primary cancer of the lip can be accomplished with nearly 100 per cent success by surgery, radium, or x-ray if treated in time and the area removed or treated is sufficient and the dose of x-ray or radium is adequate. The chief cause of failure of surgical treatment is due to the desire for cosmetic closure and failure to remove a sufficient margin one centimeter beyond the furthest evidence of tumor. With radiation treatment it is easier to include a sufficient margin. The lip is an ideal site for the use of a radium moulage because it is accessible from three sides, however, surgery is the method of choice in young people because of the late effects of heavy radiation.

Cancer of the floor of the mouth has been most successfully treated by intra-oral radiation supplemented by interstitial radium. The use of surgery in this region is limited to only the smallest tumors because of the resulting deformity caused by scar tissue tying down the tongue.

Cancer of the gingiva because of its close association with bone is better treated by surgery, electro-

coagulation, or cautery. A combination of radiation and surgery may be indicated. When the mandible is involved a partial or hemilateral jaw resection may be necessary. This may be combined with an upper neck dissection. The treatment of cancer of the hard palate is similar to that of the gingiva.

Cancer of the soft palate is more frequently treated intraorally by radiation because of the extent of the lesion when first seen. Only the smallest of these tumors can be treated by surgery or electrocoagulation. Cancer of the tonsil and pharyngeal wall is ordinarily treated by radiation.

METASTASIS TO CERVICAL LYMPH NODES

The reasons for failure to cure cancer of the oral cavity may be observed in (1) failure to cure the primary tumor, and (2) failure to cure the metastasis in the cervical lymph nodes, or both. The diagnosis and treatment of metastasis in the cervical lymph nodes has been a subject of much discussion and some confusion. Evidence has slowly accumulated, however, to establish certain fundamental principles as a guide to diagnosis and treatment.

Cancer of the oral cavity begins as a local lesion and with few exceptions spreads progressively from one lymph node to another. In early metastasis the largest lymph nodes are those nearest the tumor and they diminish in size distally. Remote metastasis without involvement of the cervical lymph nodes is rare.

The spread of cancer cells in the lymphatic system may occur by direct extension of growth along the lymph channels or by emboli from the primary tumor or from node to node. Both types of spread may occur in the same patient, hence the futility of dealing with individual nodes and the need for block dissection removing all tissue from the primary to and including the most distant metastasis is apparent. The ideal operation, as in cancer of the breast, would be the removal of the primary tumor together with the lymph drainage area en bloc draining the area. Metastasis is ordinarily to the first lymph node and thence on down the chain. The exceptions to this rule may be accounted for by the fact that the lymph vessels do not always pass through the nearest lymph node. Early in the course of metastasis only a few nodes are involved, but a study of removed tissue indicates that usually more nodes are involved than can be palpated on physical examination.

The correct diagnosis of metastatic cancer in the lymph nodes is urgent if treatment is to be effective. It is especially desirable in the early stages when a knowledge of the early spread of the disease is most valuable. It is obvious that a few cancer cells in a lymph node cannot be diagnosed by palpation and experience has shown that cancer in lymph nodes cannot be distinguished with accuracy from other causes of enlarged lymph nodes. The error is approximately 50 per cent either way. Infection in the primary tumor frequently results in enlarged lymph nodes in the drainage area and these diminish in size as the primary tumor is treated. Nodes which are of recent origin, firm, non tender, and progressively enlarging suggest cancer. Since it is impossible to diagnose early metastasis in lymph nodes with certainty by palpation, a biopsy is as urgently indicated as in the diagnosis of the primary cancer. The difficulty of aspiration biopsy with a needle in small nodes is apparent and, if negative, has little significance. The best that can be said for it is that it may avoid a minor operation. Furthermore, there is no evidence that surgical removal of a small node by a clean dissection is harmful. Success in the treatment of metastasis as in the primary cancer is dependent on early diagnosis and when in doubt a biopsy is indicated.

The criteria for resection of the cervical lymph nodes in patients with oral cancer were carefully formulated by Duffy as follows:

Neck Dissection

INDICATED

1. Primary lesion is controlled.
2. Primary lesion is limited to one side of oral cavity.
3. Primary lesion is shown to be of highly differentiated cell type.
4. Cervical metastases are present and limited to one group of nodes in two contiguous cervical triangles.
5. Capsule of node is not infiltrated by cancer.
6. Opposite side of neck is free of metastasis.
7. No distant metastases are present.
8. Patient is in good general condition.

CONTRAINDICATED

1. Primary lesion is uncontrolled.
2. Primary lesion extends to or beyond the midline of oral cavity.
3. Primary lesion shown to be of undifferentiated cell type.
4. No metastatic nodes are present.
5. Capsule of node is infiltrated by cancer.
6. Cross or bilateral cervical metastasis are present.
7. Distant metastases are present.
8. Patient is in poor general condition.

These indications for resection of the cervical lymph nodes have withstood the test of time al-

though there are now recognized exceptions based on more knowledge and experience with the potentialities of radical surgery and combined x-ray and surgery. The experience of the surgeon with these difficult problems is of the utmost importance and a relatively high percentage of surgical failures may be justified in order to save the few. However, the surgeon cannot be expected to correct the deficiencies of late diagnosis.

It is obvious that a radical neck dissection is not justified if the primary lesion cannot be controlled. It is equally obvious that if early metastasis has occurred in the cervical lymph nodes the time required for a trial of therapy on the primary tumor may not be justified before treating the lymph nodes. If experience indicates that the primary tumor may be controlled, earlier treatment of the lymph nodes before further spread is indicated. While simultaneous treatment of the primary and the lymph nodes has hitherto carried a high mortality, the risk may be necessary. Early lesions sometimes occur in the midline and all such patients should not be denied the chance of cure because of the possibility of bilateral spread. Likewise, while cell differentiation is a valuable statistical criterion, it is not an absolute indication of the biological behavior of the tumor in the individual patient. Similarly, while the prognosis in bilateral metastasis is unfavorable, there are other factors to be given consideration rather than considering it an absolute contraindication to resection. Recent advances in pre-operative care, anesthesia, chemotherapy, and correction of nutritional deficiencies have also greatly reduced the risk of operation for the patient in poor condition.

The extent of the resection should be balanced against a knowledge of the actual spread of the tumor, as well as the potential lymphatic spread as determined by the primary site, size, duration, and histology of the primary cancer. The aim of the resection is to remove all involved tissue which means that the block of tissue must at least include the lymph node area beyond that known to be involved.

The time of the resection depends on many factors, chief among which is the presence of early metastasis. Treatment of cervical lymph node metastasis in oral cancer is as urgent as the treatment of the primary tumor. The most common cause of time lost is the uncertainty of diagnosis of early metastasis based on physical examination. When nodes are palpable and the primary is controlled or it appears it can be controlled, a biopsy is indicated since it is unsafe to make a positive diagnosis of an early node by physical examination alone. If the biopsy is positive, a resection should be done at the earliest possible time consistent with the safety of the patient.

The so-called prophylactic resection of lymph nodes is designed to remove lymph nodes of a drainage area in which cancer is expected to metastasize but which shows no clinical evidence of cancer. Prophylactic dissection should never be used unless the primary cancer has been controlled. The reasons for prophylactic dissection of the lymph glands are the difficulties and errors inherent in the diagnosis of early metastasis. There is no doubt that resection of the regional lymph nodes after control of the primary tumor and before clinical metastases are obvious will cure more patients than deferred resection. It is difficult, however, to justify a routine prophylactic neck dissection for all patients with oral cancer. The decision should be made for each patient, balancing the risk of metastasis against the risk of dissection. Due consideration should be given to the site of the primary cancer, its histology, size, duration, and the general condition of the patient, as well as his cooperation in frequently repeated careful physical examinations. When cancer of the oral cavity is treated earlier in the course of the disease and when patients and physicians become more aware of the necessity of careful and frequently repeated follow-up examinations of the regional lymph nodes, prophylactic resection will be less frequent.

The treatment of lymph node metastasis by radiation has been discouraging and in most clinics it has been abandoned in favor of surgery, except as a means of palliation or in exceptional circumstances where surgery is contraindicated. The treatment of individual lymph nodes by x-ray or radium is not justified as a curative measure because the cancer cells may not be limited to these lymph nodes. Furthermore, a cancerocidal dose of x-ray cannot be delivered safely over a large area in other than the exceptional case. Finally, there is no evidence that prophylactic doses of x-ray are of value as a curative measure. Surgery is the most effective curative measure in the treatment of cervical lymph node metastasis.

The successful management of oral cancer requires that the *general condition* of the patient be given careful attention in order that the necessary

major procedures can be carried out with the minimum risk. The healing of tissue after heavy doses of radiation involves the same fundamental principles as wound healing after surgery. The most difficult problems in wound healing are those of combined radiation and surgery. Every effort should be made to correct nutritional deficiencies, proteins, vitamines, electrolytes and anemia, as well as to prevent infections by meticulous care of the wound and the proper use of chemotherapeutic methods. Special attention should be devoted to oral hygiene to correct sepsis and remove loose or carious teeth, especially those which will be involved in radiation therapy. There is no disease in which successful treatment is more dependent on meticulous attention to detail than in the management of oral cancer.

LABORATORY AND OTHER PROCEDURES USEFUL IN THE DIAGNOSIS OF CANCER

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It is good for the morale of any group of physicians to meet occasionally to discuss progress and achievements, but it is also extremely important for us to meet frequently to discuss those problems in which our progress is either nil or very slow.

Today we are met for the purpose of re-emphasizing to ourselves the urgent need and constant importance of maintaining a high index of cancer suspicion and cancer awareness. Our State is already in the forefront of those where cancer consciousness has been encouraged and cultivated for the past 15 years. The problem of cancer detection and early treatment is facilitated, in our compact State with its population of 2 million people, by the fact that no home in Connecticut is more than 25 miles distant from a general hospital. Since there are 27 general hospitals, 21 of which have active tumor clinics, (the remaining 6 contribute their statistics to the cancer survey), it is obvious that the statistical and follow-up service thereby provided should give us a potent stimulus toward constantly increasing our efficiency in the early discovery and adequate treatment of cancer.

It long has been recognized that no physician (or clinic) can be effective in the early diagnosis and treatment of cancer unless he will take the time and make the effort to secure: (1) An adequate medical history; (2) A careful physical examination; and (3) An adequate evaluation by laboratory methods.

(1) The adequate medical history must include a review of systems with special emphasis, from a cancer viewpoint, on family history, past illnesses and operations, weight loss, weakness, dyspnoea, cough, blood-spitting, chest pain and fever. There must be strict attention given to any respiratory symptoms which fail to disappear within several weeks. We must watch for the slightest deviations from the normal in digestive tract rhythm in any patient above the age of 35 or 40. Hematuria should always call for meticulous investigation whether or not it is accompanied by pain or other symptoms. "Bleeding hemorrhoids" should never be taken for granted without an adequate examination of the rectum and colon. Bleeding between menstrual periods and bleeding or discharge after the menopause call for immediate and careful examination of the pelvic organs. The young or old female patient should never be told to "forget about the lump" in her breast until and unless her breasts have been carefully investigated.

(2) The careful physical examination should always include a search for evidence of weight loss, pallor and skin changes, edema (especially asymmetrical edema), jaundice, purpura, adenopathy, pulmonary atelectasis or fluid, and abdominal masses. In the female patient a careful examination of the breasts is indicated with gentle pressure of the breast against the chest wall and with special care in the examination of the outer quadrants. The pelvic examination should not be omitted, and in addition to the bimanual examination, visualization of the cervix is essential. In both the male and female patient a rectal examination is a must. Formerly only the consultant performed a rectal examination. Now it is conceded that no initial examination is complete without the rectal examination. It is also

a simple measure to add a proctoscopic examination if so indicated.

(3) An adequate evaluation of the patient's status by laboratory methods. The usefulness of the laboratory in its assistance toward solving the problem of early cancer diagnosis lies not so much in the quantity of the procedures which it is capable of performing but in their quality and accuracy and in the thoughtful and selective care with which its facilities are utilized by the physician. Many of the essential laboratory procedures can be done in the physician's office. Urinalysis is important with attention to the urine sediment. Blood can be drawn for serology tests to be performed in the state laboratory. A small amount can then be placed in an oxalate bottle for the blood count, hemoglobin determination, and, if desired, for an hematocrit and blood sedimentation rate determination. An excessive outlay of laboratory equipment is not necessary. If only one part of the blood count is to be done, the blood smear (film) is decidedly the most valuable of laboratory examinations. A study of the white blood cells in the blood smear will usually reveal leukemia if it is present and may reveal one of the malignant lymphomata. Plasma cells may furnish the clue to a diagnosis of multiple myeloma, especially if there is also a very rapid sedimentation rate. No longer is it considered adequate to study the white blood cells alone and allow the red blood cells and platelets to go unnoticed. We may learn much from the size, shape and hemoglobin content of the red blood cells. Macrocytosis may mean primary malignant or metastatic involvement of the liver. Hypochromia may be indicative of the slow, chronic blood loss from an ulcerated malignancy of the gastro-intestinal tract. The presence of abnormal white blood cells, immature red blood cells and decreased platelets may point toward primary or secondary malignant involvement of the bone marrow. Since more than 5,000 people die each year of leukemia in the United States, it behooves us not to neglect this simple and very useful laboratory procedure—the blood smear. The total cases of leukemia in Connecticut in the 12 year period 1935-1946 equals 1,625.

The blood sedimentation rate (B.S.R.) is, in our opinion, worth performing with each initial examination and as indicated thereafter. A persistently elevated blood sedimentation rate usually means infection, malignancy or a complication thereof. A normal blood sedimentation rate does not entirely rule out these conditions, but a persistently elevated blood sedimentation rate almost always spells trouble, recognized or unrecognized. It has been our experience, in general, that if this abnormality was ignored, we discovered our error of omission or commission within a few months. The Westergren method has given us figures which agree better with the course of the patient's illness, estimated by prolonged clinical observation, than do the other present methods which employ corrections. Obviously no laboratory method is "fool-proof" and it is therefore, quite essential to remember the importance of multiple determinations rather than placing too much weight upon any one procedure. All laboratory determinations must be viewed critically and objectively along with the patient's history and physical examination.

The test for occult blood in the stool has very great value in helping to detect ulcerated neoplastic lesions of the gastro-intestinal tract. Perhaps it has been neglected because it is so very simple. While none of the present methods is perfect, the Guaiac test, the Benzidine test and the Orthotolidin tests may prove quite helpful. The first two require several solutions and, therefore, the Orthotolidin test is increasingly useful as a very simple test. At the time the initial (or follow-up) rectal examination is done, a small amount of feces adheres to the examining glove or finger cot. This is washed into a test tube with a small amount of water and two drops of the resulting emulsion is dropped upon an Orthotolidin tablet placed upon a small filter paper. A blue stain will appear on the filter paper within two minutes if there is in the stool specimen only one part of blood in 20,000 parts of stool. We should, with this test, obtain a positive test for occult blood if there is only one drop of blood per average stool. A recent study of carcinoma of the large bowel disclosed a persistently positive test for occult blood in 67 per cent and an intermittently positive test in another 25.5 per cent, leaving only 7.5 per cent with a persistently negative test for occult blood in the stools.

The gastric analysis is a simple office or clinic procedure and, if used as a supplementary test along with the search for occult blood in the stools, may give the physician and the radiologist additional helpful information about the patient with an upper gastro-intestinal lesion. It is rarely necessary to do more than introduce the stomach tube (preferably the small tube by the nasal route), remove the fast-

ıg contents, and if no free hydrochloric acid is resent inject 0.5 mg. histamine subcutaneously and emove the final specimen 30 or 45 minutes later. . study of the gastric contents for free hydrohloric and total acid, gross or occult blood, a ıicroscopic study and an immediate study of the entrifuged sediment by the Papanicolaou technic ıay yield important information. Graham, Ulfelder nd Green at the Massachusetts General Hospital *Surgery, Gynecology and Obstetrics*, 86:257 March] 1948) recently studied 50 cases by this ıethod. Twenty-four patients proved to have carinoma of the stomach and in 15 of these (62.5 per ent) cancer cells were found. There was 1 false ›ositive. This method is obviously much less expenive (and therefore should eventually be more availble) than the x-ray fluoroscopic screening technic ısed by St. John et al at the Presbyterian Hospital n New York (*Annals of Surgery*, 119:225, 1944) in vhich 2,413 asymptomatic patients over 50 years of ge were fluoroscopically scanned for cancer of the tomach. In this group 3 cancers of the stomach vere found. It has been estimated that 50,000 more adiologists than we now have in this country vould be necessary if we were to search out gastric nalignancy in this manner. This is the most pessiıistic phase of all cancer work since the 5 year urvival rate in cancer of the stomach has never exceeded 5 or 6 per cent and is more likely to be or 2 per cent. Why does such a tragic situation exist? Because there are no early symptoms of cancer of the stomach.

Perhaps we should turn to cancer of the colon ınd rectum since here the situation is much more ›ptimistic. It has often been considered that cancer ›f the stomach is the most common cancer of the nale patient. At the Hartford Hospital a study of the 12-year period ending in 1946 gave the following results:

	STOMACH	COLON	RECTUM
Hartford Hospital	385	537	373
State of Connecticut	2,994	3,897	1,926

During that period cancer of the stomach remained about stationary and there was only a slight increase in cancer of the rectum, but cancer of the colon was almost doubled. In many centers it has been shown that 80 to 85 per cent of all rectal carcinomas are within reach of the examining finger. At the Hartford Hospital almost 50 per cent are within reach of the examining finger and 67 per cent of all cancers of the large bowel are within reach of the finger and the proctoscope or the sigmoidoscope. While the x-ray is of superb assistance in finding cancer of the stomach, ably assisted in some cases by the gastroscope, it is of even greater assistance in finding cancer of the colon. Obviously the examination should be performed with fluoroscopic control and must include lateral or lateral and oblique views of the rectosigmoid area. The x-ray cannot be expected to demonstrate rectal cancer but this is within reach of the finger or the proctoscope.

The rectal examination may disclose one or more hard nodules in the prostate. The laboratory finding of an elevated acid phosphatase gives confirmatory evidence of prostatic malignancy. The level of this enzyme in the blood may then be used to estimate the patient's response to surgery and to endocrine therapy. An elevated acid phosphatase is present in the blood of 80 to 85 per cent of patients with cancer of the prostate and its presence calls for an x-ray study of the pelvis, spine and chest in a search for metastatic spread.

The initial chest x-ray of the patient in many hospitals and most clinics gives us our one and only hope of finding cancer of the lung in a stage where it may be successfully resected. Despite the excellent advances in thoracic surgery and in anesthesia, the outlook in cancer of the lung is almost as bad (if not entirely so) as that of cancer of the stomach. Here again the earliest symptoms may already accompany a hopelessly far advanced cancer with metastases. Study of the sputum by the Papanicolaou technic has given positive results varying between 30 and 86 per cent with consistently better results if the sputum is obtained at the time of the diagnostic bronchoscopic examination.

The Papanicolaou technic has also provided valuable assistance in many instances of pleural effusion or ascites where the etiology might otherwise remain obscure for some time. It has also been used very successfully in a search for malignancy of the urinary tract.

The Papanicolaou technic is strongest and best in the identification of exfoliated malignant cells from the cervix and fundus of the uterus. Here the technic gives as high as 98 per cent positive results with cervical cancer and 90 per cent, or greater, positive results with cancer of the fundus. In adding this valuable technic to our diagnostic armamentarium, Papanicolaou has done a great service for medical

progress. It must be kept in mind, however, that only a relatively small number of physicians and technicians are yet capable of accurately using this tcehnic. Progress, therefore, must be cautious and conservative if we are not to be misled by insufficient and inaccurate technical situations.

It must be assumed that patients and physicians alike must be increasingly observant of early cancerous or precancerous abnormalities of the skin, mouth, tongue and any visible area of the body. Here the closest cooperation must exist between the physician, the radiologist and the surgeon if early diagnosis and adequate treatment is to be available.

Since lesions of the breast are usually so easily found by both patient and physician, we must concentrate ever more vigorously in the removal of any suspicious breast lesion. Only when a microscopic diagnosis is made by frozen section (and at times by more detailed microscopic study) can the surgeon be properly guided in the adequate surgical treatment of this patient.

The patient who has psychosomatic disorders may and will cause us all much difficulty in attempting to interpret his complaints. It behooves us to remember, however, that underneath or concomitant with what appear to be psychosomatic symptoms there may be lurking a malignancy. We, therefore, should not be guilty of neglecting this group of patients but should selectively use laboratory and x-ray procedures as indicated. We should also remember that a negative examination of the breast, a negative rectal examination, a negative x-ray G.I. series or barium enema, or a negative chest x-ray 1 year, or even 3 months previously, does not guarantee our patient any freedom from the development of cancer.

How then can we hope, as physicians, to become increasingly efficient in the early diagnosis of cancer, since therein lies our only hope of securing for our patient the adequate treatment which may provide a 5- or 10-year survival or a "cure"? We may only make strides toward this goal in proportion to our willingness to listen to our patients' complaints with an attentive ear, examine them carefully once or twice per year (or more often when indicated), and use selectively those laboratory procedures and x-ray examinations which seem most indicated in the individual patient.

THE STATUS OF CANCER IN CONNECTICUT

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In the short time at my disposal it would be impossible for me to satisfy all of you in describing the status of cancer in Connecticut. Since I have been more or less intimately connected with the organized effort of cancer control in this state for a number of years, it is possible for me to make some remarks which may serve as the basis of discussion, for this is a conference and not a series of lectures.

It is significant that this conference is a joint endeavor of the Connecticut Cancer Society and the Connecticut State Medical Society in which the former furnishes the funds and acts as instigator and the latter furnishes the personnel. Public interest in cancer is intense and Connecticut citizens have joined with those of other states in contributing generously to voluntary funds in the hope that cancer can be controlled more effectively. In addition to these voluntary contributions federal funds in even larger amounts have been added. In fact many Congressmen were disposed to make the amounts larger than could possibly be expended with wisdom and profit.

It has not always been like this and those of us who have been concerned with this movement from the start can take justifiable pride in the part that members of this Society have played in developing the present program of cancer control. If it had not been for the intelligent, persistent pioneering work of individual physicians, many of whom are present

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in this audience, Connecticut would not stand as it does today in the forefront of states which are embarked on intelligent cancer control programs.

The pattern of a state cancer control program is now fairly well defined and it rests on a cooperative effort of Medical Society, Cancer Society, and State Department of Health. Each has its part to play. The stability and effectiveness of our program in Connecticut arises from the fact that physicians assumed leadership at the start and intend to play their full part in maintaining that leadership. Our program grew from the bottom up, not from the top down. It was an outgrowth of the intense interest in cancer in our hospital staff groups. This interest called for a Tumor Study Committee of the State Society. This interest metastasized to every hospital in the State. It was this interest which finally persuaded the General Assembly to establish the Bureau of Cancer and Chronic Diseases in the State Department of Health. It is this interest of physicians and ancillary workers which justified state subsidies to develop the complete reporting and follow-up of cancer cases. It is this interest which makes compulsory reporting by statute unnecessary in Connecticut, and it is this interest also which brings you here today.

One may remark parenthetically that no group so much as physicians is ready in season and out of season to admit that it does not know all there is to be known but needs constantly to be refreshed from the waters of the spring of knowledge, and all of us know that in the field of cancer that knowledge is not yet perfect. But we know also that it is unfolding rapidly and we must make the new knowledge available to our patients.

The records of cancer patients in Connecticut have been reported by our hospitals and have been accumulating since 1935 and are subject to study in the State Department's Cancer Registry. We have already had numerous reports and papers from the Division of Cancer Research concerning its organization, its methods of operation and so forth, but so far there have been all too few studies of a clinical nature. One such study will be spoken of this afternoon by Dr. Ottenheimer. Another study by Dr. Donald Wells of cancer of the breast at the Hartford Hospital received valuable data and assistance by the Bureau of Cancer and Chronic Diseases.

We need many more such clinical studies. We must make ever increasing use of this huge reservoir of facts. We want to know the survival rates of all of the various types of cancer, and we look to see them published year by year for the whole State. I am sure that Dr. Griswold and Miss MacDonald and their helpers will receive your hearty support in enlarging the field of usefulness of the records.

Those who realize the wealth of material at hand and the fact that it is available on punch cards are impatient for more information. The usefulness of the Cancer Registry is almost limitless. A hospital can ask what are its five year survival rates in various types of cancer. In fact the time should come when each hospital will be informed of its survival rates automatically. It will know what its "batting average" is as compared to the State as a whole. If then a hospital staff discovers that its 5 year survival rates are consistently below the average, it will be led to inquire into the cause. In the interest of giving its patients the best possible care it cannot afford to allow its results to be inferior.

Dr. Griswold has just completed a summary which will be published in the near future. I understand that his Bureau has been bombarded with questions, many of which this publication will answer. These questions have come from nearly every state in the Union and from many foreign countries as well. Those who ask realize that this Registry is a perfect gold mine of morbidity information, and with Dr. Griswold's permission I am going to describe some of the fundamental facts which his tables demonstrate. Some of these have been available in mimeographed form already.

His first table shows mortality rate per 100,000 adjusted to age and sex from the years 1935 to 1946 inclusive. Mortality rates have increased from 111.6 to 119.1. They show a tendency to level off for males and a slight tendency to fall for the females, and he calls attention to the fact that death rates tend to lag about two years behind the morbidity rates.

His second table deals with morbidity, in other words the incidence per 100,000 population. In the male, cancer has increased from 114.5 to 254.2; in females, from 145.9 to 260.6. He points out that certain sharp increases in morbidity apparently occur as a response to certain things which have happened in our program for cancer control. For example, increases are noted in the number of cases reported following the establishment of the Division of Cancer, following the establishment of the Association of Connecticut Tumor Clinics. Again in 1941 when the state funds were distributed to hospitals,

in 1944 when the first American Cancer Society's campaign for funds occurred, and again he thinks that there is an increase in 1946 following the subsidized visitations of physicians to tumor clinics throughout the State. There is therefore an indication that some of the things which we have been doing have actually been productive in diagnosing cancer more quickly. Since hospitalization is furnished by insurance to forty per cent of all people who use hospital services in Connecticut, it may have been a factor also in earlier diagnosis and more complete reporting.

In Table III he shows the incidence according to the site of the lesion. In Connecticut we have many females in advanced age, hence the larger number of cancers in this group.

In Table IV he analyzes the delay factor and there appears to be a distinct improvement from 1935 to 1946. He comes to the conclusion that in general one is justified in saying that one-fifth of patients come for treatment within 1 month of the earliest symptoms, two-fifths within 4 months, and one half within six months. Ten years from now we will be able to set up figures and really learn whether we are making progress.

Table V shows the average age at which cancer patients begin treatment for males is 59.6 years and for females, 55.4. This table is broken down according to sites.

Table VI shows the percentage of distribution according to age and sex of 3,000 cases who have been alive for 5 years or more. It thus appears that in our present population, out of 100,000 people 174.5 have already survived 5 years or more after being treated for cancer, and there are all told at the time of compiling these tables 9,000 individuals living subsequent to cancer treatment.

In Table VII he studies the factor of accessibility for early diagnosis and concludes that in males one-third and in females two-thirds of all cancers are easily accessible.

In considering Table VIII he discusses the reasons for delay according to the various sites and he concludes that there is improvement in the adequacy of medical advice given to patients, particularly with cancer of the breast, stomach and other digestive organs and of the genital urinary organs.

How about the cancers which are difficult to diagnose such as those in the chest and in the abdominal viscera? In Table IX he shows that there is an increased incidence of these cancers. This means better diagnostic work is going on.

In Table XI he studies the survival rate of patients who have microscopically proven cancer. Five year survivals have increased from 22.1 to 33.5 per cent. Those who are alive after one year beginning treatment have increased from 42.4 to 58.9 per cent. In this table also are the survival rates for the other years.

I know that all of you who are students of the cancer problem will await with interest the publication of Dr. Griswold's paper and its accompanying tables, and I sincerely hope that the State Department of Health will find it possible to utilize the columns of the Connecticut State Medical Journal for publication of all of this clinical material. If this is done regularly, I can assure the Commissioner that the profession in Connecticut will maintain and increase its interest in this division, for these are facts which primarily concern our physicians. They are our patients and it is an analysis of the way we treat them.

I hope that we will soon be able to focus more accurately on the survival rates of various types of cancer. I am interested to know the relative merits of different types of treatment of cancer of the cervix begun at different stages of development. I would look for an answer to the question as to the value of pre-operative radiation of cancer of the endometrium. I expect that the Division of Cancer and Chronic Disease will be bombarded with questions of this nature in the near future, and I have no doubt that the State Department of Health will continue to cultivate the most intimate relations between its Division of Cancer and Chronic Disease and responsible groups of physicians in the state. If this is done with intelligence and good feeling, I am sure that our patients will benefit, and that the status of cancer in Connecticut will always be as it is today—improving.

CANCER OF THE PROSTATE

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Cancer of the prostate is a malignant disease which, by virtue of its location, may be diagnosed early. Early diagnosis makes possible radical surgical treatment with the expectancy of cure or long palliation in a large proportion of cases. Since the older people in our population are increasing, the problem of cancer of the prostate becomes more important as time goes on.

INCIDENCE

Cancer of the prostate is the most common malignancy affecting the male genito-urinary organs. In a ten year survey by Griswold,[1,2] who kindly sent me his published statistics relative to cancer of the prostate in Connecticut, one notes that prostatic carcinoma accounts for approximately 10 per cent of hospitalizations for cancer among males, and 4½ per cent of the total, male and female, for cancer. Six per cent of cancer deaths are from prostatic cancer. As of April 1947, 29.1 per 100,000 population in Connecticut are under treatment for cancer of the prostate. In any year about 10 new cases per 100,000 will be discovered.

Viewed from a national perspective, the facts are perhaps more striking. United States Health Service Report by Harold F. Dorn states that the incidence of cancer of the prostate is 22 per 100,000 male population, or 10 per cent of cancer in the male. These figures were arrived at by using the total urban population of the United States in 1940. Cancer of the prostate is the third most common cancer in the male. Skin cancer occurs in 17.4 per cent and gastric cancer in 14.2 per cent of males. The incidence of prostatic cancer is insignificant before age 45. After age 45 the incidence is as follows: 45 to 54 years, 3.1 per cent; 55 to 64 years, 16 per cent; 65 to 74 years, 15.4 per cent; 75 and over, 19.1 per cent. After age 65 cancer of the prostate is the most common visceral cancer and is second only to cancer of the skin. In 1945 there were 10,145 deaths from cancer of the prostate among white males in the United States, a rate of 14.6 per 100,000 population, and 11.8 per cent of all cancer deaths.[3]

Pathological studies give us still more information concerning the frequency of prostatic cancer. Rich,[4] and Moore[5] have examined prostates removed at autopsy from men over the age of 50, most of whom did not die of cancer of the prostate and were not suspected of having it before death. In some cases routine sections were examined. In others serial blocks were made. Carcinoma of the prostate was found in from 14 to 20 per cent of the cases. Cancer varied from frank, gross involvement of the gland to tiny occult foci found only on careful search. Baron and Angrist[6] examined the prostate by serial sections in a series of unselected, consecutive autopsies of 50 men over the age of 50 and reported the incidence of occult carcinoma to be 46 per cent. There has been and still is some difference of opinion among pathologists as to the criteria for diagnosis of early prostatic cancer so that complete agreement might not be possible in a consideration of statistics relative to the pathological occurrence of early cancer of the prostate, but even so it is apparent that the longer we live the more chance there is that such foci may develop into clinically recognizable cancer.

From a clinical standpoint it is well to remember that, as stated by Hugh Young, benign prostatic hyperplasia and cancer are co-existent in about 75 per cent of cases and that of 100 cases of prostatic obstruction about 20 will be found to have cancer.

PATHOLOGY AND PHYSIOLOGY

There are certain generalizations relative to pathology of cancer of the prostate which have a bearing on its diagnosis. It usually devlops as an adenocarcinoma of a scirrhous character which renders it firm to the touch. It tends to be slow growing. It may arise from single or multiple foci in the periphery of the gland. It most frequently originates in the posterior lobe of the gland. Occasionally it may develop from the tissues about the urethra or in areas of hyperplasia. Adenocarcinomata of the prostate vary in degrees of differentiation, rate of growth; and probably, because of these inherent differences responds varyingly to stimulation and inhibition by

hormones. At least 10 per cent of prostatic cancers are undifferentiated. No gland formation is visible. Cells grow in solid masses which invade widely. These cancers are much more malignant, grow and metastasize more rapidly, and in general are not influenced by hormone administration or withdrawal. Such cancers may not have the firm character that we associate with adenocarcinoma and for this reason may not be recognized so easily.

Local extension of cancer of the prostate occurs upward to the bladder neck and trigone in some cases, but its principal course is by way of the lymphatics along the seminal vesicles, in particular the perineural lymphatics. It is by this route that metastases to the lumbosacral vertebrae are thought to occur (Warren, Harris, and Graves[7]). Metastases occur most commonly to pelvic lymph glands and bones of the lumbar spine and pelvis. Distant metastasis to ribs, long bones, and perhaps the pelvis must occur by way of the blood stream. Visceral organs are involved much less frequently. Bone metastases are usually of the osteoblastic type, although both osteoblastic and osteolytic metastases may be present in the same individual. X-ray of the lumbar spine and pelvis are usually sufficient to determine the presence or absence of bony metastases.

In 1936 Gutman, Sproul, and Gutman[8] discovered that prostatic cancer, like normal prostatic tissue, contains acid phosphatase; sometimes in very large amounts. Further work by the Gutmans[9] and by Barringer and Woodard[10] at the Memorial Hospital in New York, carried out independently and reported in 1938, demonstrated that in certain cases of carcinoma of the prostate abnormally high acid phosphatase levels were present in the blood. This has led to the serologic blood acid phosphatase test for cancer of the prostate. We have since learned that acid phosphatase levels are, in general, elevated only when bone or lymph gland metastases have occurred, so that this test is of no value in the diagnosis of early cancer of the prostate. The serum acid phosphatase estimation is useful in verifying the diagnosis or as an aid to diagnosis when it becomes necessary to differentiate between Paget's disease of bone and metastatic prostatic cancer, or in the presence of large, local prostatic growths which could conceivably be prostatic, rectal, or vesical in origin. Furthermore, serial blood phosphatase levels taken before and during treatment may provide a means of estimating the efficacy of treatment.

A modification of this test rests on our ability to stain sections of tissue removed at biopsy to show acid phosphatase using the method of Gomori.[11] This is particularly helpful in the differentiation of vesical and prostatic lesions. It may also be used in the study of nodes removed from superficial areas. It is possible to assay the acid phosphatase content of tissues removed at biopsy or operation which, under certain circumstances, may be of aid in diagnosis or therapy.

The King and Armstrong method of estimation of the blood acid phosphatase is reported in units of acid phosphatase. Since acid phosphatase is formed in some tissues other than the prostate, blood levels up to 4.5 units may be considered normal. Values between 5 and 10 units may be considered suggestive of the presence of prostatic cancer, but elevations of 7 to 8 units have been observed in liver disease and other conditions. Values over 10 units may be considered diagnostic of cancer of the prostate with metastases.

The present endocrine therapy for cancer of the prostate reported by Huggins[12] in 1941 was probably suggested by the work of the Gutmans. The demonstration of acid phosphatase in prostatic carcinoma led to the conception that carcinoma of the prostate resembled normal prostatic tissue quite closely and might respond to hormonal stimulation and withdrawal. Clinical studies proved this to be correct. Cancers of the prostate may be divided into two groups—androgen sensitive and androgen independent. The basis of this seems to be that the androgen sensitive growths are not completely autonomous, but are made up of sufficiently mature tissue to be influenced by the administration or withdrawal of androgens. Such cancers grow or diminish in size when androgens are given or taken away. In general the androgen sensitive prostatic carcinomata are the adenocarcinomas as one might expect and the androgen insenstive growths are the undifferentiated cancers. Since there are variations in the two groups and they tend to merge into one another, there may be overlapping so far as endocrine response is concerned. Huggins demonstrated, and this has been amply confirmed, that androgen sensitive cancers are stimulated by the injection of male hormone (androgen) and are inhibited by reduction, elimination (orchiectomy), or by neutralization through the administration of female sex hormone (estrogen). By frequent observations of the serum acid phosphatase levels, it was found that

decreasing the amount of androgens by castration or by administration of estrogen in the form of diethylstilbestrol, 5 mg. daily, often caused a decrease of serum acid phosphatase values to or toward normal, and marked and rapid clinical improvement; whereas, injection of androgen (testosterone proprionate), 25 mg. daily, caused exacerbation of the disease and increase in the acid phosphatase values. Orchiectomy or the administration of estrogens has become the standard treatment for extensive cancer of the prostate. Further details of therapy will be discussed later under the appropriate heading.

HISTORY

Early cancer of the prostate, as is true of early cancer generally, is asymptomatic. If one were to depend upon symptoms for the diagnosis of cancer of the prostate, it is quite likely that no case would be seen early enough for cure. Attention is usually directed to the prostate and cancer found because of symptoms due to developing urinary obstruction or back pain. Sometimes demonstration of bony metastases by x-ray, made in an effort to explain pains of an ill defined nature in the back or thighs, may give the first clue to the origin of the trouble. Hematuria is not a symptom of early cancer of the prostate, inasmuch as the cancer originates and develops in the peripheral portions of the gland and invades the urethra and bladder neck only late in the disease.

DIAGNOSIS

Of all visceral cancer, prostatic cancer is the easiest to diagnose, since in the majority of cases, all that is necessary is a careful rectal examination. Although this is true, it must be stated with regret that most cases of cancer of the prostate are recognized only in late stages of development. This must be due either to the failure of doctors to do rectal examinations as a routine part of physical examinations, or their failure to properly interpret what is felt. Perhaps another factor is the undoubted tendency of physicians to adopt a complaisant attitude toward the diagnosis and treatment of cancer of the prostate engendered by the feeling of many that cancer of the prostate cannot be cured. One must be guided by the thought that a suspicious lesion is cancer until proved otherwise, rather than the hope that cancer is not present. Cancer of the prostate should be considered whenever a rectal examination is done on a patient over age of 45. No physical examination can be considered complete unless a rectal examination is done. Yearly rectal examinations are necessary if we are to diagnose early cancer of the prostate and rectum. This is true, regardless of previous prostatectomy for benign hypertrophy, because the possibility that cancer may develop in the remaining prostate is no less real. It is my custom to ask all patients to come in once a year at least for rectal examination, and I tell them the reason, for this is apt to impress them.

Assuming that careful rectal examinations are done, the next point is to be able to recognize, or at least be suspicious of, prostatic cancer. A few words about the technique of rectal examination may not be amiss. In the first place, it is necessary that examinations, so far as possible, be carried out in the same way. It is surprising, when one is in the habit of using a certain technique, how unsatisfactory another method may be. The best method in my experience is to have the patient stand bent over at the waist with elbows on the knees and the legs slightly apart. In this position there is easiest access to the gland; it is palpated in a horizontal plane so that symmetry or the lack of it will be apparent. The examiner may stand or seat himself so that he is comfortable. The gloved finger should be well lubricated and prior to insertion of the finger the anal region should be inspected. The finger should not be roughly and quickly inserted, but slowly with regard to discomfort on the part of the patient and the palpation of internal hemorrhoids or polyps. Spasm of the sphincter may be avoided by gentleness. Next, the wall of the rectum within reach of the examining finger should be carefully palpated. The hollow of the sacrum should be examined for mass or tenderness. The prostate and vesicles should be lightly palpated so that the examiner has a general overall impression of the size of the gland, symmetry, and general consistency. If possible the vesicles should be outlined as separate entities. Sometimes this is difficult if the vesicles are empty or if the prostate and vesicles are matted together as the result of chronic prostatovesiculitis. If distended, the vesicles may be palpated as soft, elongated bodies springing from the base of the prostate and extending upward and outward obliquely from a central plane. If empty, the vesicles are indistinctly felt as soft connective tissue above the prostate to either side of the bladder base. If the gland is elastic, smooth, symmetrical, and the size of a walnut, it may be considered normal.

The differential diagnosis of prostatic lesions must take into consideration fibrosis due to chronic prostatitis, prostatic calculi, tuberculosis, localized

nodules of hyperplasia firmer than normal, and carcinoma. The diffusely enlarged, adenomatous prostate of elastic consistency rarely presents a problem in diagnosis. However, occasional very cellular, soft carcinomas may be confused with hyperplasia. Extensive carcinoma characterized by diffuse, stony induration, nodulation, and extension up about the bladder base and into the pelvic tissues is obvious to most everyone. What we are looking for are patients with lesions in an early state of development, still confined to the gland and recognized by localized induration either as a rounded nodule, a raised, plaque-like area, or as an ill-defined area of induration that shades off into the normal elastic consistency of the gland. When such a lesion is found the physician should not rest content until malignancy has been excluded or until proper surgical treatment has been carried out. Localized areas of fibrosis due to an old prostatitis may require biopsy. Calculi can usually be determined by x-ray of the pelvis. Crepitation may be felt if calculi rub together. A word of caution must be written. Just because calculi are demonstrated by x-ray, the thought of cancer should not be too abruptly dismissed since calculi and cancer may be co-existent. If the position of calculi by x-ray does not conform to the palpated area of induration, biopsy must be considered, and in any case the patient should be kept under careful observation and biopsy done if progression of the lesion suggests cancer. Tuberculous lesions may be confused with cancer, but they are apt to be multiple, or one area may be soft, caseous and therefore feel like a crater in the gland. One must depend sometimes on accessory findings, such as evidence of renal tuberculosis, chronic epididymitis, etc., to help. Areas of hyperplasia or a myoma may require biopsy before one may be sure of the exact nature of the lesion.

Given a lesion which may be considered suspicious of carcinoma, the following additional diagnostic aids may be utilized. (1) X-ray of pelvis and lumbar spine. This will rule out prostatic calculi and metastatic lesions in the bones. Paget's disease may be differentiated by acid and alkaline serum phosphatase determinations. (2) Prostatic massage may be potentially dangerous because of the possibility of disseminating tumor, but the information gained thereby offsets the dangers. A localized area due to retention of secretion may soften on massage or disappear. Pus may be found in the expressed secretion which would warrant a series of massages for both diagnostic and therapeutic reasons. Furthermore, it is becoming evident that sometimes cancer cells may be demonstrated by Papanicolaou stains of the secretion. This is worthwhile trying. (3) Biopsy of many lesions is possible by using the Silverman needle. This is a large caliber needle inserted into the prostate either through the perineum or the rectum. The technical details are important but simple. The needle with its stylet is introduced through the perineum under the guidance of a finger in the rectum. It is directed toward but not into the area in question. The stylet is withdrawn and then the cutting blades are inserted and pushed through the lumen of the needle on through the lesion. The needle itself is then pushed in over the cutting blades to cut free the cylinder of tissue enclosed; and, lastly, the needle with its enclosed cutting blades and cylinder of tissue removed. In this way a very satisfactory biopsy specimen may be obtained. A negative biopsy specimen must not be taken too seriously since a small lesion may be difficult to pierce. Further needle biopsy may be done or, if the lesion is quite small, it may be better to perform (4) a biopsy through a perineal incision, with the intention of carrying out radical perineal prostatecomy if cancer is found. This is the usual procedure, but the writer questions the soundness of opening up an area of cancer which could possibly be disseminated in the pelvic tissues during the subsequent operative manouvers. It would seem better to occasionally remove a non malignant gland than to chance the spilling of cancer cells. Biopsy by transurethral resection will practically never be possible in early cancer of the prostate, inasmuch as the lesion in the majority of cases develops, as noted previously, in the periphery of the gland. In extensive lesions transurethral resection is the usual method of obtaining tissue for microscopic study and for relief of urinary obstruction. (5) Acid phosphatase estimation should probably always be done, although elevation is unlikely unless extensive, unrecognized lymph gland or bony metastases are present. The value of this is to prevent one from making the mistake of attempting radical removal of local operable disease when metastases have occurred.

In view of the undoubted fact that 10,000 patients die every year in this country with carcinoma of the prostate, we should be able to find many early, operable, and potentially curable cases if we look for them. In support of this thesis, it is interesting to find that at the Pratt Diagnostic Clinic in Boston,

due to the inquiring attitude of the residents, I have examined 15 to 20 patients during the last year that I considered to have early cancer of the prostate. Several of these patients were operated by me and proved to have carcinoma. This Clinic performs to a very considerable extent the function of a cancer detection clinic. It simply supplies the information that early cancer of the prostate is frequently to be found if searched for. Theoretically, all cancers of the prostate must be operable and curable at some stage in their development.

TREATMENT

Cases may be divided into 3 groups. *The first includes those patients with disease confined within the prostatic capsule* or, at most, with extension to the base of the vesicles and without demonstrable metastases. This may be difficult to determine with accuracy. One depends on the rectal findings, serum acid phosphatase determination, x-rays of chest, spine, and pelvis, and the absence of demonstrable lymph gland involvement. Such cases are potentially curable and should be so regarded and treated. Provided there are no serious medical contraindications and the life expectancy can be considered reasonable, or if the patient is not too old, radical perineal prostatectomy (Young) is indicated. This operation consists in removal of the entire prostate gland, the seminal vesicles, proximal vasa together with their enveloping fascia and lymphatics, and the bladder neck. Mortality is very little higher than for conservative prostatectomy; convalescence is smooth; functional results are excellent. Incontinence occurs rarely and is no problem in the hands of a well trained perineal surgeon. Statistics relative to the operation are as follows:

AUTHOR	YEAR	NUMBER	PER CENT MORTALITY	RESULT
Rolnick	1936	17	.....	
Hinman	1939	21	14.2	50% cures
Creevy	1942	10	10.0	
Belt	1942	50	4.0	58% cures
Henline	1943	7	.....	
Young	1944	184	6.5	nearly 50%
Ormond	1947	27	0.0	
Smith	1948	95	6.3	41% without disease
Huggins	1948	2	0.0	
Leadbetter (unpublished)	1948	18	0.0	
Total		431	Average 5.89	41-58% without disease

Undoubtedly this list is incomplete, but at least it emphasizes the excellent results which can be obtained by radical operation in suitable cases. It also shows how little effort the physicians and surgeons of this country have expended in an effort to diagnose and cure early cancer of the prostate. When one considers that this operation was described in 1906, more than 40 years ago, and that 10,000 males die of the disease every year, one is forced to conclude that we have made little use of a procedure that gives results far better than most operations for the cure of cancer. It is often stated that there is little use in doing the operation, because the perineural lymphatics are invaded early, or that some patients with cancer of the prostate are known to have lived 10 to 15 years without treatment. These arguments are falacious as evidenced by the presented facts in the first place, and by the fact that the average duration of life after onset of symptoms before the advent of endocrine therapy was 18 to 24 months and even now probably not over 30 months. It is true that occasional patients with cancer of the prostate have lived years with slow progression, but these cases are rare and simply prove the exception to the rule.

The second group includes patients with disease which has progressed too far locally to be removed with hope of cure by the radical perineal prostatectomy, but in whom one can find no evidence of metastases. It is presumed that disease has involved lymphatics about the vesicles and perhaps pelvic lymph glands as well. Colston[13] has suggested that stilbestrol therapy be tried first. If a good response takes place as evidenced by marked reduction in size and consistency of the local growth, then radical perineal prostatectomy may be performed. If cure is to be hoped for under these conditions, one would have to postulate actual death of tumor cells in lymphatics from estrogen effect. I am not aware that this has been demonstrated. It would seem better, under such circumstances, to plan an operation that can be expected to remove the pelvic lymphatics and glands as well as the prostate and vesicles. This entails uretero-enterostomy followed by total prostatocystectomy and pelvic lymph gland dissection. Such an operation would be applicable only to younger, vigorous individuals with a long life expectancy. I have carried out this operative procedure in two instances with good immediate results. One patient has lived 20 months without sign of recurrence. The other has been done too recently to evaluate. It seems likely that, in addition

to the removal of the pelvic organs and lymphatics, orchiectomy should be done or stilbestrol given to provide every chance for cure or long palliation.

The third group consists of the vast majority of patients with cancer of the prostate. It includes all patients with very extensive local disease with or without metastases. There is no hope of surgically eradicating the disease. Treatment is directed toward maximum palliation. Until 1941 this consisted of relieving urinary obstruction by conservative prostatectomy—perineal or suprapubic and by transurethral resection. As regrowth of tissue occurred resection was repeated. Deep x-ray therapy was used sometimes locally in an effort to retard the growth of the cancer and more often to relieve pain of bone metastases. As the growth progressed to involve the membranous urethra and triangular ligament, suprapubic cystostomy sometimes was necessary to relieve retention of urine.

This same situation exists so far as androgen independent prostatic cancers are concerned—undifferentiated cancers. Fortunately, these make up only 10 to 20 per cent of the total. One cannot be sure how a particular cancer will respond to estrogen administration or orchiectomy, but the absence of elevated acid phosphatase in the presence of extensive bone metastases and the demonstration microscopically of undifferentiated cancer in a biopsy should suggest that little may be expected by hormone therapy.

The usual well differentiated prostatic cancer may be expected to respond to either orchiectomy or stilbestrol administration. The period during which the disease may be controlled is unpredictable. It would appear that, in general, patients live somewhat longer than before the advent of hormone therapy, though this is not yet a certainty. The main advantages of present day therapy are that patients are relieved of the pain from metastases, improve generally, gain weight, feel well, and due to the effect on the local growth which may become much smaller and softer, sometimes to the point where a diagnosis of cancer is no longer possible. Symptoms of urinary obstruction may be relieved and transurethral resection not be necessary. Some few cases respond so completely (4 of the 20 cases originally presented by Huggins[14] are in this group) that no clinical or laboratory evidence of cancer is present years later. Huggins' 4 cases have remained well from 6½ to 8 years after orchiectomy. The usual result is that after an interval of complete freedom from symptoms the cancer seems to break away from hormonal control, become entirely independent, and death ensues as before.

At the present time, our general plan of treatment is to do bilateral orchiectomy as soon as the diagnosis of inoperable cancer is made. It appears that better results are to be expected from this than the administration of stilbestrol alone. Inactivation of androgens by stilbestrol is attractive, but there are theoretical and practical reasons why orchiectomy is better. The inhibition of androgens by estrogens is not complete. The administration of estrogens must be continued as long as the patient lives and estrogens are carcinogenic themselves. We have seen one patient develop cancer of the breast after 2 to 3 years of stilbestrol. Patients may not always be trusted to take the drug regularly. There is reason to think that it may be well to administer estrogens following castration. This is based on the knowledge that the adrenals produce some androgens and it is felt that certain failures have been due to this. Another argument, aside from the neutralization of androgens formed by the adrenals, is the possible inhibitory effect of stilbestrol on the anterior pituitary to suppress the formation of adrenotropic and gonadotropic hormones which might be responsible for the stimulation of adrenal production of androgen (Nathanson).[15]

If one chooses estrogen therapy rather than orchiectomy, how much stilbestrol should be given? There is no information available which answers this question adequately. Our custom is to give 5 or 6 mg. daily, but equally good results have been observed with the use of only 1 or 2 mg. Some writers recommend much larger doses. Following orchiectomy we usually give 1 or 2 mg. daily.

There is little evidence to show that orchiectomy will give further palliation once the cancer has become active under stilbestrol therapy, but, theoretically, it seems worthwhile trying. When urinary obstruction develops, transurethral resection is the procedure of choice for relief, unless the external sphincter is involved. The use of an indwelling urethral catheter or suprapubic cystostomy will then be necessary. Deep x-ray therapy is still temporarily helpful to relieve pain from bone metastases. Occasionally chordotomy may be desirable when the number and location of metastases precludes the use of x-ray.

PREVENTION

Though we do not yet know the cause of prostatic cancer, we have unmistakable proof that in most cases it is stimulated to growth by androgens. Pathological studies, as pointed out earlier in this paper, have disclosed the fact that the prostates of many men over the age of 50 have foci of carcinoma which were unrecognizable clinically before death. It would therefore appear that the thoughtless administration of androgens to men over 50, for the purpose of stimulating lagging sexual function, or for use as a tonic, should be condemned. If it is to be given for extended periods, careful check on the prostate should be made. I have recently performed radical perineal prostatectomy for proved prostatic cancer on a patient who received testosterone for some months during the previous year.

The performance of prostatectomy by either the suprapubic, perineal, or transurethral routes is no guarantee that cancer may not subsequently develop in the remaining gland, since this is the part that tends to undergo malignant degeneration. This is borne out by the fact that 15 per cent of a series of 200 patients who underwent prostatectomy at the Massachusetts General Hospital for supposedly benign hypertrophy were either found to have cancer in the removed tissue or subsequently developed it (Woodruff).[16] This suggests that we should advise and carry out total prostatectomy whenever possible for benign hypertrophy, rather than enucleation of hyperplasia. The operation is actually easier and convalescence smoother. This should be explained to older patients who have no sexual function or desire for the same. This would, no doubt, prevent the development of cancer in a significant number of patients.

Finally, the performance of prostatectomy-enucleation, or resection of the hyperplastic spheroids in a benign gland is no guarantee that cancer will not subsequently develop, so that these patients should be watched just as carefully as any male patient over the age of 50 by rectal examinations.

If we could put all these known facts into a concerted plan for diagnosis and treatment, cancer of the prostate would not be the scourge of older men that it is today.

BIBLIOGRAPHY

1. Griswold, M. H., and MacDonald, E. J.: Statistical Reports from the Division of Cancer and Other Chronic Diseases. Connecticut State Department of Health, April 1947.

2. Griswold, M. H.: Cancer of the Prostate in Connecticut. The Connecticut State Medical Journal, 10:106, February 1946.

3. Vital Statistics of the United States, 1945; United States Bureau of the Census Population—Special Reports, Series p-47, No. 3.

4. Rich, A. R.: Journal of Urology, 33:215, 1935.

5. Moore, R. A.: Journal of Urology, 33:224, 1935.

6. Baron, E., and Angrist, A.: Arch. Path. 32:787, 1941.

7. Graves, R. C., Warren, S., and Harris, P. N.: Tran. Am. Assoc. Genito-Urinary Surg., 1936, p-179-205.

8. Gutman, E. B., Sropul, E. E., and Gutman, A. B.: Am. J. Cancer 28:485-494, 1936.

9. Gutman, A. B., and Butman, E. B.: Proc. Soc. Exper. Biol. and Med., 39:529-532, 1938; J. Clin. Investigation, 17: 473-478, 1938.

10. Barringer, B. S., and Woodard, H. Q.: Tr. Am. A. Genito-Urinary Surgeons, 31:363-369, 1938.

11. Gomori, G.: Proc. Soc. Exper. Biol. and Med., 42:23-26, 1939, and Arch. Path., 32:189-199, 1941.

12. Huggins, C., and Hodges, C. V.: Cancer Research 1:293-297, 1941, and Huggins, C., Stevens, R. E., Jr., and Hodges, C. V.: Arch. Surg., 43:209-223, 1941.

13. Colston, J. A. C.: J. A. M. A., 127:69-72, 1945.

14. Huggins, C., and Johnson, M. A.: J. A. M. A. 135:1146-1152, December 1947.

15. Nathanson, I. T.: Proc. Laurentien Conference, New York, Acad. Press, Inc., 1947, Vol. 1.

16. Woodruff, L. M.: Personal Communication.

CANCER OF THE COLON AND RECTUM

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The Author. *Surgeon-in-Chief, Windham Community Hospital, Willimantic*

THE greatest good which can come from a meeting of this kind is an opportunity to discuss frankly how we can improve our results in the treatment of cancer. If we consider specifically cancer of the colon and rectum, we have much to be proud of, and at the same time much remains to be done. The management of malignant disease is a complicated, cooperative undertaking which involves first, an intelligent awareness of early symptoms by the patient so that medical advice is sought at once; second, early recognition of these symptoms by the physician so that proper diagnostic steps may be taken; and third, prompt and adequate treatment by the surgeon or radiologist. Success in the management of cancer of any organ will be in direct proportion to the degree to which each of these conditions approaches the ideal.

PERCENTAGE DISTRIBUTION OF CANCER
BY SITE
BOTH SEXES - - - 37,863 CASES
1935 - 1946

SITE	PERCENTAGE DISTRIBUTION
COLON and RECTUM	15.4
BREAST	13.8
UTERUS	10.2
STOMACH	7.9
PROSTATE	4.7
LUNGS	3.5
SKIN	Excluded

Taken from Report of Division of Cancer and Other Chronic Diseases-
Connecticut State Health Department

Chart No. 1

It is safe to say that the results in the treatment of cancer of the colon and rectum in the past 10 years leave much to be desired, despite the fact that in Connecticut it is the most commonly encountered cancer.

Chart No. 1 shows that out of 37,863 cases between 1935 and 1946 cancer of the colon and rectum occurred more frequently than breast, uterus, and even stomach.

Results of the treatment of cancer of the colon in this State have not as yet been compiled, but the literature is replete with reports from many large teaching hospitals and clinics where one might expect the most brilliant achievements. Many of these end-results are misleading because the 5-year survival and cure rates are based frequently upon only those cases that were resectable, and in many instances only on those surviving radical surgery. Such reports ignore for statistical purposes the not inconsiderable group which came too late for curative or even palliative treatment.

CANCER OF THE COLON
5-YEAR CURES ON RESECTABLE CASES*

WITH NODAL INVOLVEMENT	32.0
WITHOUT NODAL INVOLVEMENT	55.5

* Rankin, F.W., and Olson, P.F.- The Hopeful Prognosis in Cases of Carcinoma of the Colon S.G.& O. 1933.

Chart No. 2

Chart No. 2 is based on Rankin's resectable cases and it should be noted that in those cases in which regional glands were involved 32 per cent were cured at the end of 5 years. When no glands were involved, 55.5 per cent were cured at the end of 5 years. This is a representative series so it might be conservative to state that if results included non-resectable cases the total salvage of cancer of the colon might not exceed 30 per cent.

In regard to the rectum, accurate statistics from the Division of Cancer Research of the State Department of Health are available. Between 1935 and 1941 there were 735 cases admitted to our hospitals with a diagnosis of cancer of the rectum. Only 12 per cent of the total original group survived 5 years, and only 7 per cent were free from the disease at the end of a similar period. These results are somewhat startling and call for a critical insight into the factors which have contributed to this dismal picture in the past.

REASONS FOR BAD RESULTS

1. NATURE OF TUMOR
2. LOW OPERABILITY RATE
3. EXCESSIVE OPERATIVE MORTALITY RATE
4. DELAY IN RECOGNITION

Chart No. 3

Chart No. 3 lists some of the factors which it is reasonable to suggest have played their fateful role.

1. NATURE OF TUMOR

It is well known that in the bowel, rapidly growing, highly anaplastic tumors arise, particularly in young people, which are often symptomless until metastases have occurred in some distant organ, usually the liver. Until there is discovered some entirely new approach to the diagnosis of malignant disease, this group of cases will continue to influence adversely our good results. Fortunately these tumors are the least frequent. Indeed in the Connecticut series of both colon and rectal cancer, over 75 per cent of all cases occurred in individuals over 50, in which these rapidly growing tumors are the exception rather than the rule.

2. LOW OPERABILITY RATE

In the past 10 years the operability or resectability rate has been low, primarily because about 40 per cent of patients have been admitted in a stage which permitted only palliative or no treatment whatsoever. In a small percentage of cases, however, particularly in rectal cancer, part of this low resectability rate has been due to the fact that surgeons with little experience in the radical surgery for cancer have done a palliative operation when the recorded stage of the disease suggested radical surgery might have been possible. In other words, in Connecticut about 59 per cent of cases of rectal cancer were recorded as being admitted in stage 1, yet the resectability rate was considerably below this figure.

3. HIGH OPERATVE MORTALITY

It is fashionable to impugn the general practitioner for a great deal of the poor results in cancer, yet it must be admitted that the surgeons should come in for their share. In the past 10 years the operative mortality for radical resections of the bowel and rectum has been high, and it is little wonder that the laity and the medical profession have become skeptical of the surgeon's ability to extirpate a cancer in these organs with reasonable safety. Ten years ago the published operative mortality from some of our nationally known clinics and hospitals ranged from 12 to 20 per cent. In the past 11 years the operative mortality in Connecticut based on over 600 radical resections for cancer of the rectum was about 21 per cent. Needless to say one cannot expect many 5-year cures on patients who do not survive operation.

4. DELAY IN DIAGNOSIS

This is perhaps the most important factor in the poor results of the past in the management of cancer of the colon and rectum. Several years ago studies were made of the delay factor, and it was found that in certain types of cancer the patient was chiefly responsible for delay. In gastro-intestinal cancer, however, a preponderance of patients sought the advice of a physician early in the disease, and it was the physician who was responsible for the delay in establishing the diagnosis and hence instituting prompt treatment. This was not true of the breast and other important sites, but there seemed to be something about an alteration in gastro-intestinal routine which prompted the patient to seek medical advice within a reasonable time, even without educational publicity.

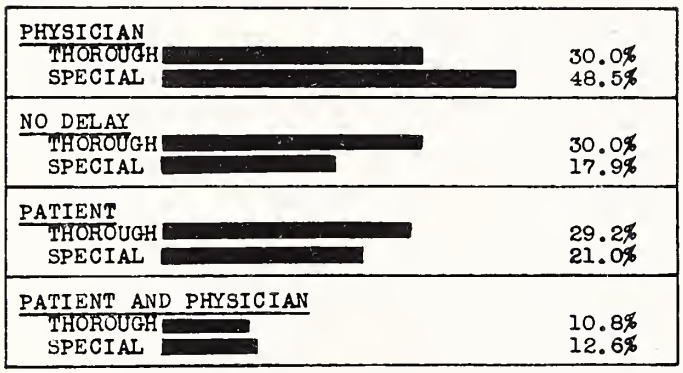
These findings were confirmed recently by Leach and Robbins who have made a significant contribution to the study of the delay factor.[1] They divided cancers into 4 groups: (1) Superficial; (2) Breast; (3) Thorough; (4) Special.

Chart No. 4 has been modified from their originals and includes only the "thorough" and "special" groups. In the "thorough" group they included those malignant tumors which could be detected or suspected by a careful history and a thorough physical examination; examples of this are cancer of the female genital tract and distal rectum. The "special"

group included those malignant tumors which could be detected or suspected by a careful history and physical examination, plus radiographic studies, or some form of endoscopy, or both. Examples of this group are of the gastro-intestinal tract, as well as lung, kidney and bladder, and primarily, of course, cancer of the gastro-intestinal tract.

It shows that in the "thorough" group there was no delay in 30 per cent, the patient delayed in 29 per cent, the physician delayed in 30 per cent, and patient and physician both delayed in 10 per cent.

RESPONSIBILITY FOR DELAY
IN THE DIAGNOSIS OF CANCER*



* Leach, J.E., and Robbins, G.F. - Delay in the Diagnosis of Cancer, J.A.M.A., Sept. 6, 1947.

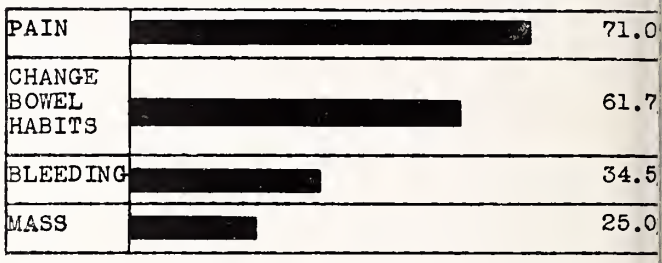
Chart No 4

This was in a group which required only a history and physical examination to detect. In the "special" group which includes cancer of the colon and rectum, there was no delay in 18 per cent, the patient was responsible in 21 per cent, and the physician was at fault in 48 per cent. The patient and the physician together contributed to the delay in 12 per cent, so that in 60 per cent of cases the physician played some part in the delay.

This is a rather severe indictment and at first glance suggests that the early symptoms of cancer of the colon and rectum must be so obscure and subtle that the suspicion of the physician is not easily aroused. It might be of some interest, therefore, to investigate the character of common presenting symptoms of cancer of the colon and rectum.

It has been an accepted dictum that the symptoms of cancer of the colon depend upon the location of the tumor. Structurally the colon from the cecum to the rectum becomes progressively smaller in diameter. Physiologically the function of the right half of the colon is one of absorption and accumulation. The left colon function is storage and expulsion. Pathologically cancers of the right colon are as a rule, non obstructive, friable, fungating lesions. Those of the left colon are hard, annular lesions tending to produce early obstruction.

SYMPTOMS OF CANCER OF THE RIGHT
AND TRANSVERSE COLON*

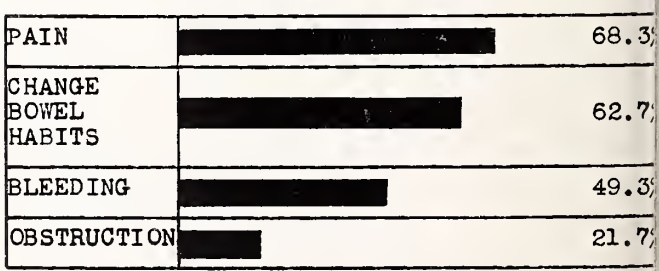


* Coller, F.A., and Berry, R.L.- Cancer of the Colon - J.A.M.A., Dec. 20, 1947

Chart No. 5

The pain in cancer of the right colon is apt to be vague and may resemble appendicitis, spastic colon, gall bladder, and even duodenal ulcer. But there is, in a large proportion of cases, a change in bowel habit, and bleeding from the rectum. The secondary anemia which often accompanies cancer of the right colon is not always proportional to the amount of bleeding. It is not certain that there is a satisfactory explanation of the unusual anemia of this lesion, but as a rule the operability or prognosis cannot be made on the basis of the degree of the anemia. Early resectable lesions of the right colon often are associated with severe anemia.

SYMPTOMS OF CANCER OF THE LEFT COLON*



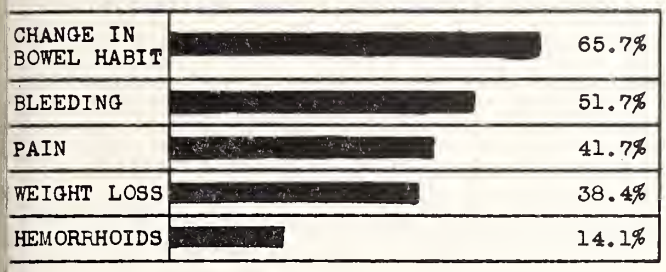
* Coller, F.A., and Berry, R.L.- Cancer of the Colon - J.A.M.A., Dec. 20, 1947.

Chart No. 6

Chart No. 6 shows that, just as in cancer of the right colon, the most common symptoms of cancer of the left colon are pain, change in bowel habit and bleeding. The pain of cancer of the left colon

s more apt to be crampy in character, suggesting obstruction. Severe anemia in cancer of the left colon almost always means extensive inoperable disease in contrast to the right colon.

SYMPTOMS OF CANCER OF THE RECTUM



rom the registry of the Division of Cancer and ther Chronic Diseases, Connecticut State Depart- ent of Health.

Chart No. 7

Chart No. 7 shows the most common presenting symptoms in 1,610 cases of cancer of the rectum in this State. Again there are pain, alteration of bowel habit, bleeding, and, in addition, hemorrhoids. In 14 per cent hemorrhoids were the first symptom and many of these received treatment for hemorrhoids before the malignant lesion was discovered. The striking thing about these symptoms is that regardless of location, the 3 outstanding symptoms of cancer of the right colon, cancer of the left colon, and cancer of the rectum, are pain, change of bowel habit, and rectal bleeding. Now these are not obscure or subtle symptoms, certainly not to the patient who usually seeks a remedy for them relatively promptly. Why then is there such a delay on the part of the physician in the detection of cancer of the colon and rectum?

FACTORS INVOLVED IN DELAY

1. FAILURE TO SUSPECT CANCER
2. FAILURE TO ADVISE X-RAY EXAMINATION
3. FAILURE TO DO A RECTAL EXAMINATION
4. FAILURE TO DO SIGMOIDOSCOPY

Chart No. 8

1. FAILURE TO SUSPECT CANCER

This is perhaps the most important aspect of the problem. If a physician suspects cancer then he is much more apt to follow through with appropriate recommendations and examinations. It cannot be over-emphasized that if a patient, particularly one in the cancer age, presents the symptoms which have been pointed out above, cancer should be suspected at once.

2. FAILURE TO ADVISE X-RAY EXAMINATION

X-ray examination is of comparatively little value in the diagnosis of cancer of the rectum. Above the rectum, however, x-ray is the most reliable and valuable guide to the existence and location of a malignant tumor of the colon. Nevertheless x-ray examinations are often unnecessarily postponed, mainly because of the physician's reluctance to incur excessive expense on the part of his patient. But if a patient does have a change in bowel habit, abdominal pain or bleeding, x-ray studies of the colon become imperative. The physician who does not urge the patient to have x-rays at this point may be jeopardizing his patient's one chance of a cure.

3. FAILURE TO DO A RECTAL EXAMINATION

This has resulted in missing many cases of early cancer of the rectum. Over 95 per cent of rectal cancers can be found by a carefully done rectal examination.

4. FAILURE TO DO SIGMOIDOSCOPY

Many physicians feel that sigmoidoscopy is a formidable procedure and should be done only in the hospital. This is a myth which should be discarded, for with proper preparation and moderate skill, sigmoidoscopy can be done as an office procedure by the average physician. If more sigmoidoscopies were done when symptoms warranted, many growths would be discovered which lie just beyond the examining finger.

All of which adds up to this, that our delay in reaching a diagnosis is due more often than not to our failure to take a careful history of symptoms, and to follow it with a thorough examination.



PHOTOGRAPH

The picture shown above is by Chandler, an early Colonial painter whose work is just now receiving the recognition it deserves. It was painted in 1770 and illustrates the character of a physical examination of that period. One can see at a glance how seldom a physician of those days would detect an early cancer of the rectum. Obviously we have gone a long way since that time. Furthermore, patients no longer object to having a complete physical examination; in fact, it is the experience of tl detection centers all over the country that patien are eager and willing to have frequent and mo complete examinations.

Finally, on the basis of present trends, what is tl outlook for improvement in the future in the resul of treatment of cancer of the colon and rectum?

FACTORS INVOLVED IN IMPROVEMEN OF RESULTS

1. EARLIER DIAGNOSIS
2. RISING OPERABILITY RATE
3. DECREASING OPERATIVE MORTAL- ITY RATE

Chart No. 9

The greatest hope for improvement lies in earli diagnosis by the physician. That great advanc are being made in that direction is shown to a cor siderable extent by the rising operability rate of th past few years. Coincident with this rising oper bility rate has been a steady decline in the operativ mortality rate in radical surgery for cancer of th large bowel and rectum. An operative mortalit rate of 21 per cent for such procedures is no longe justifiable in any hospital. The physician who di covers cancer of the bowel early can assure h patients that appropriate surgery can now be a tempted with great safety and he can be confide of a high percentage of cures.

REFERENCE

1. Leach and Robbins: Delay in Diagnosis of Cancer, Jou A.M.A., September 6, 1947.

CANCER OF THE LUNG

GUSTAF E. LINDSKOG, M.D., *New Haven*

esented at the State Cancer Conference, New Haven, March 25, 1948

The Author. *Professor of Surgery, Yale University School of Medicine*

)RIMARY carcinoma of the lung is one of the more common of malignant tumors. About 10 per cent all visceral carcinoma is lung carcinoma. We think at this disease is actually on the increase. That, wever, is only a clinical impression at the present ne, and is not based on any scientific evidence.

The subject today is to be considered in terms of fferential diagnosis, diagnostic procedure and erapy, with particular attention to the problem of ignosis.

The statistical data in our original group of 100 ses was terminated after a five-year period end- g in December, 1943. We have had a second con- cutive group of 100 cases which was completed July of 1947, and we are condensing these statis- ally to present you the data today.

You will see that this is a disease largely of the ale, in the ratio of about 5 to 1. As a matter of ct, in the second group of cases the ratio is higher an that. The peak incidence is in the sixth decade d at the age of 57. The types of tumors that we ve to deal with are squamous adenocarcinoma and aplastic. Perhaps the more common type is the aplastic, the second, squamous cell tumor fre- ency of a well differentiated epidermoid nature. ese tumors have the expected sex incidence of 5 10 to 1, whereas the adenocarcinoma have a more rmal sex incidence, and this is borne out in both ries of cases.

The symptoms of this disease are easily described r a majority of patients. A man in his 50's or 60's gins to have for the first time a cough or a pain in e chest. The pain at first is slight, sometimes a mere llness, a feeling of discomfort. These two initial mptoms alone or together constitute 59 per cent the cases. There are other complaints which may present as first symptoms, however. You will tice that bleeding as a first symptom is not very mmon, only 6 per cent. If you wait for that in the erage case (and it will occur in about 50 per cent of the cases sometimes), you are going to have far advanced lesions. A little cough or a change in the character of a cough, chest pain in a patient who has coughed slightly for a long time, a mild discomfort- ture of feeling of fullness in the chest; a wheezing sensation are the common manifestations. Most other symptoms that are listed are the result of metastases, and they have no significance in terms of early diagnosis.

DIFFERENTIAL DIAGNOSIS

To go over rapidly some of the differential diagnostic problems, I will show you illustrative roentgenograms of cases who were sent to us with a presumptive diagnosis of cancer of the lung, and in whom the various diagnostic studies or subsequent surgery have disproved this diagnosis.

It is fortunate that we have this type of case coming to see us because it means increasing attention on the part of the attending physician and earlier diagnosis. The first patient was sent to us as a tumor suspect at age 31. She had a little pain in the left upper chest. About one year previously a film showed a small area of infiltration in the left upper lobe with a highlight which had persisted in all of the films and can possibly be seen in the present slide. The lesion was in the apical segment of the upper lobe. This patient had a strongly positive tuberculin but the sputum and gastric washings were negative for tubercle bacilli. However, she was submitted to an exploratory operation with a diagnosis of tuberculoma and that was verified by the excised specimen. The lower lobe re-expanded after the upper lobe was removed and completely filled the left pleural cavity. The patient is now well.

The second patient was in a somewhat younger age group, a female of the middle 20's. She came to us with a story of pain in the chest and a slight cough, and because of that was subjected to exhaustive diagnostic studies which proved absolutely nothing. She was running a low grade fever. Her tuberculin was positive. She had a negative sputum for tubercle bacilli. She was finally explored and biopsies of the lung were taken from the medial aspect of the upper lobe which showed a chronic

inflammatory tissue of a non specific type. Only 3 years later with the development of a chest wall sinus did we have the true diagnosis in this case, which was actinomycosis.

The third group of cases which we have in differential diagnosis are cases of chronic pulmonary abscess based either on aspiration or embolic infection. The illustrative patient was aged 52, and the tentive referring diagnosis was carcinoma. He had had two months of left anterior chest pain but he was running no fever. He had a slight elevation of white count. The clue to diagnosis in this case lay in the history of an acute abscess on the left cheek some 6 weeks before the onset, which drained internally and presumably represented in this case the source either of direct aspiration or of emoblic infection. After 3 weeks of penicillin and sulfonamid therapy the lesion regressed, and the final x-ray shows the almost complete resolution of the infection in the axillary portion of the left upper lobe.

The next illustrative case is a patient 24 years of age, a male, who again presented to us as a tumor suspect with a history of 8 months of right chest pain, cough, a certain amount of malaise, with low grade fever and blood turgid sputum. The tuberculin was negative and sputum likewise. Bronchoscopy was negative. His roentgenograms showed a very considerable density in the right anterior lung field and mediastinum. The biopsy of the lung revealed Hodgkin's disease. This diagnosis could not be ascertained by any previous biopsy of peripheral lymph nodes. He was subjected to a course of x-ray therapy totaling 5500 R to lateral and anterior parts and the end result was a considerable clearing. He was lost to follow up 3 years later, at which time he had not had significant recurrence of symptoms and the chest film was still clear. But I do not doubt that he has not survived to the present date.

This is the result of the therapy some 6 weeks later and, as I say, the follow-up was lost.

From the industrial standpoint, another important differential diagnostic problem which may simulate carcinoma is silicosis. The illustrative case was a man of 48 who had worked for about 25 years in a foundry in a nearby town. He came to us with a history of anterior chest pain and cough. This had been present only for 2 months although some degree of so-called "cigarette cough" had been present for many years. He was given the usual diagnostic study with negative results all around including axillary lymph node biopsy and bronchoscopy.

A laminographic study of the chest showed a considerable density which could not be separated from the right hilus shadow. Because of this it seemed urgent to explore the right lung. In this case we found very large hilar lymph nodes. They were biopsied and they showed fibrosis and definite silica crystals. He was subsequently compensated by the State Courts for his silicotic disease and has continued. Interestingly enough, he had some improvement in his condition based perhaps on the rest and the transient effect of effusion in collapsing the lung.

The next case is a circumscribed, dense, non pulsating lesion in the left chest. The patient was a male of 54 years almost in the peak of the carcinoma age incidence, with 2 months of left chest pain. Venereal history was negative and serology normal. We suspected, despite the admitting diagnosis of tumor, that this was a vascular lesion from its association with the descending aorta. He was subsequently proved by exploration to have a saccular thrombosed aneurysm of the descending aorta. This is not a common differential diagnostic problem in this community but it has to be borne in mind.

Another diagnostic problem which comes up not infrequently in the middle age female is the so-called bronchial adenoma. We look upon bronchial adenoma as a benign but potentially malignant tumor. There are certainly cases of benign bronchial adenoma in which, on rare occasion, lymph nodes are involved but usually the involvement is confined locally to the hilus. The reaction of these cases after resection, in our experience, has been that of a benign lesion without recurrence and a very good prognosis. These cases are frequently female. They have the normal sex distribution as do the adenocarcinoma. It is suggested that adenocarcinoma may arise from small lesions of this type, possibly over the course of many years. As illustrative of this tumor we present roentgenograms from a female of 28 who had a very large tumor which occupies most of the right lower lobe and which is cutting off the intermediate bronchus rather sharply at the level of the middle lobe which was bronchiestatic. It is not a serious mistake to recognize these tumors as carcinoma, of course, because the treatment is that of resection. However, there may be a somewhat more limited operation than is usually the case with carcinoma.

LOCAL COMPLICATIONS OF LUNG CANCER

Some of the local complications of lung tumors affect the problem of differential diagnosis. We

present the roentgenogram of a 64 year old patient who had what seemed to be an ordinary empyema of the right chest. A thoracentesis revealed thick white pus which grew type III pneumococcus in profusion.

Replacement of the effusion with some air helped demonstrate a hydropneumothorax with a considerable collapse of the right lower lung and a good deal of density in the hilus. In view of the patient's age we bronchoscoped him on the basis of the peculiar appearance and somewhat to our surprise we found a carcinoma of the intermediate bronchus. It was a squamous cell tumor. So we were confronted with the problem of a primary carcinoma which had produced an obstructive infection and was associated with empyema. The point I want to make about this type of case is that you must not treat the empyema conservatively by simple drainage. The only thing that will help the patient is a combined drainage and resection operation.

If this patient had been operated on in prechemotherapy days he would probably have died. He was treated before we had penicillin, but we were fortunate to have sulfathiazole to control the secondary infection in this case. His pleural cavity was sterilized, his thoracotomy wound healed per primum. Now 6½ years later this patient is carrying on his farming business in Bethel.

There is another type of complication, also inflammatory in nature, and this is the apparent pneumonic complication of carcinoma. The illustrative patient was relatively young. She was aged 36, and had a little cough for about a year. However, for one month she had not been feeling well, and 6 days before admission to the hospital she had had a chill with high fever, a high white count, and a great deal of pain in the left anterior chest. The presumptive diagnosis in this case was left upper lobe pneumonia, and there was a type 24 pneumococcus in the sputum. She was treated conservatively with sulfa drugs on the private medical service and seemed to improve. At the end of about 2 weeks she was discharged from the hospital, but not with a completely clearing lung.

Two weeks later the readmission x-ray examination was made and we saw a picture in the left upper lobe very similar to what was present at the time of the original acute disease. She had a negative bronchoscopy at exploration. We found a widely spreading tumor of the upper lobe. She recovered from resection but lived only 15 months to die of metastatic disease in the other lung. The histologic picture was adenocarcinoma.

The third apparently inflammatory complication of bronchogenic carcinoma is abscess. I would emphasize that you must not be deluded in the age groups 40 to 70 by the clinical appearance of a lung abscess, because 10 to 15 per cent of such patients have carcinoma of the lung. The abscess develops on the basis of an obstructive pneumonitis, but perhaps more commonly as an ischemic necrosis and infection with a subsequent central sloughing out of the infected and necrotic tumor tissue. The illustrative case was a recent one who had a complaint of pain in the chest and cough, with a low grade fever and a very large amount of foul sputum. The lateral x-ray projection shows particularly well a definite spherical abscess cavity in the right upper lobe pectoral segment with a definite depression of the inbilobar fissure between it and the middle lobe. This finding of a depression on the fissural side of the lesion with a tendency to irregular nodulation in its wall is an important one in diagnosis of tumor complicated by abscess. Sputum cytologic studies were made and they were positive for tumor cells. More will be said about that technique later. The patient was subjected to a single stage pulmonary resection. Here again I would emphasize that preliminary drainage of these abscessed tumor areas is never indicated. If you do that you will probably not have the chance later to carry out the necessary resection. It is important to emphasize again that when carcinoma is complicated by an empyema, or by obstruction and acute pneumonitis as in the second case, or by abscess, the treatment is still direct and definitive, a single stage resection. Fortunately we now have chemotherapy to help us along with the pre-operative preparation of such otherwise risk cases, and with that the immediate results are surprisingly good.

TISSUE DIAGNOSIS

Among 200 consecutive and unselected cases, 83 per cent had a positive tissue diagnosis either in the living or at autopsy. Disappointingly enough the bronchoscope has not been the complete key to the diagnostic lock in our experience, as it has been apparently reported to be in some clinics in this country. We have been able to *prove* carcinoma by the bronchoscope only in 39 per cent of those patients who have been bronchoscoped, and 29 per cent of the patients in the total series.

Exploration and resection have yielded the first tissue specimen in a surprisingly large number of

cases. Of 72 patients who have had exploration or resection, 51 came to operation without a previous positive tissue diagnosis. That is worth emphasizing because if you are going to wait for positive tissue diagnosis you are going to miss the main chance to do something in a great many favorable cases. If the clinical history is presumptively that of carcinoma and you have roentgenogram findings persisting for several weeks to support it, do not hestitate to advise the patient to have an exploratory thoracic operation in order to settle the issue.

One may ask, how often does one get into difficulties from the standpoint of misdiagnosis and unnecessary exploration. Of the many explorations we have done, only 8 times have we found a lesion where the actual condition was not carcinoma. Most of these cases were chronic abscess or pneumonitis, with complications, and they were not prejudiced by this exploratory procedure. On the contrary, most were cases who could well benefit by resection therapy.

The other diagnostic procedures that we have to use are aimed chiefly at the establishment of the tissue diagnosis in the presence of metastatic disease and are of interest largely in the management of the inoperable case from the standpoint of roentgenogram therapy or radium. One does not like to treat carcinoma of the lung presumptively, and would like to have tissue diagnosis in every case. Therefore we go after the metastatic nodes or the metastatic bone lesions and the like for diagnostic and prognostic purposes. From the standpoint of the case who may be favorable and entirely operable, we have to rely on our clinical judgment, on the bronchoscope direct exploration, and one other procedure which is the sputum cytological studies.

This technique is the evolution of many different people's work, and is a technique similar to the Papanicolaou smear for the cervical lesions you have already heard about today.

Apropos of this technique I will illustrate the type of case that you are up against in early diagnosis and therapy. The patient was a 64 year old ward porter in our own hospital. He was not feeling very well at the time that he had a routine x-ray survey film. The film was taken not for that reason but because he was up for re-employment in another position. The lesion was in the axillary portion of the right upper lobe, not larger than a 25-cent piece on a regular film, and from the standpoint of pulmonary complaint entirely asymptomatic. Bronchoscope, of course, was negative. It doesn't help you in this type of case. Sputum cytologic study was also negative and we explored on the basis of the man's age, the appearance of the lesion, and the fact that on a successive film there was evidence of slightly progressive axillary infiltration. At operation a squamous cell carcinoma was found, and a right lobal pneumonectomy was carried out successfully. After a study of the specimen you can see why the bronchoscopy would be negative in this case. There is a tumor well out in a tertiary bronchus of the lobe. The lymph nodes in this case were negative, both intrapulmonary and in the hilus. We think that this patient should have a reasonably good prognosis.

There is another case in which the sputum cytological study did help us a great deal. This patient, 45 years old, had a 3 months story of discomfort or pain in the left upper anterior chest, a slight cough for 2 years with an insignificant amount of sputum. Bronchial smears were obtained at the time of the diagnostic bronchoscopy which was otherwise negative, and they were positive for tumor cells. With that information we explored the patient's left chest. We found lymph nodes in the hilus, which were biopsied and were negative, so we took a direct biopsy of the lung. That proved to be negative. With some trepidation we did an excision of the left lung based on the clinical, or rather the roentgenological, picture, and on the positive cytological study. The excised lung specimen showed a small carcinoma in the pectoral bronchus of the upper lobe. There is no question that this type of case makes it well worth while to pursue many, many cases with sputum cytological studies in order to turn up the occasional positive results that will help towards the eventual early diagnosis and the proper surgical therapy, as we understand it now.

Dr. Averill Liebow has studied altogether about 1,000 sputum and bronchial smears. Remember that the slides were presented to this pathologist without his knowledge of the clinical condition of the patient, without even his knowing the name of the patient, the age or sex, or the diagnosis. In the sputum studies he has averaged 3 slides per patient. He has determined a positive diagnosis in 44 per cent of the cases where carcinoma was subsequently proved to be present. He has had false positive reports of 5 per cent in patients where we believe carcinoma does not exist, but there is some possibility of error on our part there.

The technique of getting material at the time of bronchoscopy, rather than expectorated sputum, has yielded somewhat different results. We have employed two methods. One is irrigation of a bronchial segment with saline, and the other is a direct smear with a dry swab. We now prefer the second technique, transferring the material directly to a dry clean slide, and fixing it with ether and alcohol. In this group of cases which, of course, averaged only a single examination per patient there were 30 per cent positives in subsequently proven cases and again a margin of error in the neighborhood of five per cent. However, if we take the sputum cases and analyze single examination technique, one slide per patient, we find that there were positives only in 15 per cent as against 33 per cent for the bronchoscopic technique. Therefore the bronchoscopic smear technique does have a little more to recommend it. One would expect that to be the case from the standpoint of avoiding dilution phenomena because of a more direct examination of the tumor bearing area bronchial segment.

THERAPEUTIC RESULTS

We must admit that the over-all therapeutic picture in this disease is rather grim. I will say that this is not the fault merely of late diagnosis. In our experience the patients who have been operable, resectable, and in some cases curable, have had no briefer average duration of symptomology than the group who were not explorable, or who were submitted to exploratory operation and were not found resectable. I am not advocating delay, don't misunderstand me, in this connection, in fact the reverse. We do, however, have a problem in this disease and that is the position of the lesion and its histological character.

In the group of 200 cases the inoperables were 61 per cent, and 3 per cent refused treatment, making a total of 64 per cent. 36 per cent of the cases were presumably operable and explored. For various reasons (mediastinal extension, metastases, pleural implantation, high position on the trachea or primary bronchus) we were able to remove the lesion in but 33 cases, or 16½ per cent. The hospital mortality was 6 or 18 per cent of the resected cases. Ten patients are living after resection. This represents 5 per cent of the total case material, or 37 per cent of the successful resections. The inoperable patients who have had no special treatment whatever lived an average of 4½ months. Those who had radiation with no other treatment lived an average of 6 months. Those who had exploratory operation followed by radiation therapy lived 14 months.

I would leave you with the thought that there is future hope in this disease by paying attention to early, insignificant symptoms, by the careful examination and evaluation of patients who turn up with questionable lesions on routine survey films. We have a technique for mass survey studies for resection which has a reasonable and still declining mortality. With the opportunity to see patients from the survey group and patients with minimal symptoms of cough and chest discomfort we can predict that the next 100 cases is going to show a very much more encouraging performance.

AMERICA'S FIGHT AGAINST CANCER

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EFFORTS to control cancer, of whatever kind, by whatever group, pursue one or the other of two objectives. The first of these objectives is the knowledge of the essential nature of cancer and its causes; and the corollary of this, the discovery of effective methods of treatment and even prevention. Although recent years have recorded a gratifying increase in the quantity and the quality of investigative effort, the results in aggregate appear to have greater significance as the surveying, staking and marking of the area to be worked, rather than as the identification of the rich lodes which lie beneath. Recognizing that the ultimate answer to cancer, the major medical problem which remains, must come from the laboratory, and that the answer may be 5 or 500 years in coming, we look to the second objective: the effort to control cancer, today, now, by increasing the effectiveness of already known methods of detection, diagnosis and treatment. This objective is, in my judgment, much less ephemeral than the promises of research. There is abundant evidence that cancer, even the major forms of cancer, is curable in respectable degrees. There is, on the other hand, clear evidence that the number of cures achieved is pitifully small. The optimum curability and the cures accomplished present a striking dichotomy, a dichotomy which is a forthright challenge to every sensible adult, layman and doctor alike.

It is a coincidence of unusual interest that the first measurable steps toward these two objectives were taken in the same year—1913. In that year Yamagiwa succeeded for the first time in producing cancer at will, by painting the ears of rabbits with coal tar. This marked the beginning of laboratory research as we use the term today. In that same year a group of public spirited laymen and doctors with vision brought forth the American Society for the Control of Cancer, a voluntary health agency. The formation of this Society was suggested by the America Gynecological Society and its original stated pur poses were to "disseminate knowledge concernin the symptoms, diagnosis, treatment and preventio of cancer, to investigate the conditions under whic cancer is found and to compile statistics in regar thereto."

Consider for a moment the general picture of th time—and remember that it was only 35 years ag Cancer stood eighth in the list of causes of deat pre-empted by heart disease, tuberculosis, pneu monia, nephritis, intracranial lesions of vascula origin, diarrhea, enteritis and ulceration of the intes tines, and accidental deaths. Nevertheless, an esti mated 71,000 per year were dying of it, or 1 in ever 18. Such fragmentary research as existed was mor of alchemy than science. There was but one cance hospital. There were no cancer clinics. The federa government was unconcerned. State governments with one exception, did not recognize any aspect o cancer as a responsibility. No word of cancer ap peared before laymen. Nowhere was cancer report ed for morbidity records. The value of the biops was still a topic for discussion in medical meetings To be sure those were exciting days for the radia tion therapists who were eagerly exploring th effects of roentgen rays, generating them at highe and higher voltages, filtering them to increase thei tumor selectivity, focusing them with greater pre cision and determining units of dosage. The appli cation of radium in a variety of forms was bein hopefully undertaken, although the cost $100,00 per gram (about 5 times its present price) delaye its more general use. Surgery still bore shreds of it frock-coat chrysalis and expert surgical treatmen was available only in limited quantities, so far a curing cancer went. Actually the operation for th cure of cancer of the stomach was only 30 years old the radical hysterectomy had been perfected onl 16 years before and the radical treatment for cance of the rectum was still an innovation. Relatively fe surgeons were willing to risk the formidable mortal ity entailed in attempting surgical cures of cance

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umors of the lung, esophagus, pancreas and of the entral nervous system were not yet surgical diseases. nesthesia was limited to two or three agents of mited flexibility. Fluid balance, salt physiology, utritional reserves were little understood and blood ansfusion was still an emergency operation. Medial education in general remained unstandardized nd medical degrees conferred by diploma mills, and y Hopkins and Pennsylvania were accorded equal ecognition by licensing boards.

Accepting the challenge presented by many of hese inadequacies, the Executive Committee of the merican Society for the Control of Cancer at its rst session set $10,000 as the goal for fund raising nd began the task of teaching 100,000,000 people omething they definitely did not want to hear bout. The first important article to appear in a ublic information medium was written by Samuel Hopkins Adams, and was entitled "What Can We Do About Cancer—The most vital and insistent uestion in the Medical World;" a prophetic title, or if it was not the most vital question, it has ecome so. It appeared in the *Ladies' Home Journal* n May 1913. The lay educational activities of the ociety continued uninterruptedly and with slowly ncreasing momentum. The structure of the Society rew by degrees so that within 10 years it had beome a loose federation of affiliated State organizaions.

Appropriations by state governments for conrolling cancer were spearheaded in 1898 when the tate Legislature of New York appropriated $10,000 or a two year program of cancer research to be onducted in the State Health Laboratories. The rogram grew from one of laboratory investigation o include facilities for diagnosis and treatment. n 1912 a small hospital was built, the first state can-er hospital in the country. In 1919 the State Departnent of Health in Massachusetts was authorized to pend a sum "not exceeding $3,000" for the purpose f gathering information about the prevalence of ancer and for purposes of prevention and control f the disease. I should like to offer here a tribute o Massachusetts for the leadership its State Health Department has provided in recognizing cancer as community health concern and in acknowledging ts direct responsibility thereto. So early as 1899 the pparent increase in cancer in the state was the subect of a widely discussed statistical analysis, the Whitney report. In that same year the Harvard Cancer Committee was appointed, a group which has been of much value in the development of the state cancer program. Its State cancer hospital at Wrentham was placed in operation in 1937. Other state government programs followed in modified patterns. The services provided by state appropriations included support of hospital clinics, direct case assistance and tissue diagnostic service. A few states provided for the reporting of new cancer cases under systems of legal warrant, but the effectiveness of this would not be known for some years to come.

In 1929 the American Society for the Control of Cancer appointed a small committee to study and report on the adequacy of cancer treatment in the United States. The Committee in commenting on its findings suggested the organization of groups of competent specialists into teams which would, at the local hospital level, bring their collective talents to bear on the complex problem of diagnosis and treatment presented by individuals with cancer. The proposal was carried to the American College of Surgeons, the regents of which agreed to formulate standards for such Cancer Clinics, and to inspect them for approval. The soundness of this principle of cancer service has been eloquently demonstrated in the steady extension of such clinics throughout the country. As time went on and experience was gained, it became clear that there were some institutions capable of providing complete cancer diagnostic services, although they were not able to meet the standards of the Cancer Clinic which combines diagnostic with treatment facilities. Therefore, the College established a second category of cancer service, the Cancer Diagnostic Clinic.

It is unlikely that prior to 1937 more than $800,000 was spent in any year in support of basic investigative efforts on cancer. These funds were derived almost entirely from foundations, from university treasuries and from investigators pockets. The two sources of support which have since come to mean the most, government and public contributions, had not yet come forth. Moreover, much of the research being conducted tended to seclude itself in interest-tight compartments. This tendency has two conceivable advantages: first, it assures the integrity of individual initiative and freedom of inquiry; second, it permits the proper degree of privacy for those investigators whose interest in scientific discovery derives from a desire to get there first, to make the long awaited advance, in a word, to best the field. The spirit of competition does supply the drive of

many otherwise pure scientists, and there is nothing odious about it, so far as I can see. While it is true that intense focusing of interest and high degrees of specialization are more apt to result in scientific progress, it is true up to a certain point only. Beyond that point, which I must admit is a foggy blur, such catholic adherence to interests of preconceived importance acts like blinders on a horse. The scientist becomes incapable of seeing the enticing and possibly more fruitful by-ways he is passing. Therefore some degree (I would hope a very great degree) of association with other investigators, perhaps even those in quite different fields of effort, is desirable. Good minds cross seed each other. In a more general sense perspective is maintained, which is especially important today as our knowledge increases in 40 different facets of cancer at one time. Further, systems of rugged individualism make it difficult to train young scientists and to interest young potential scientists. Training in research does not differ basically from other kinds of training. Certainly it should be general before it is specific.

Therefore I believe the laboratory which maintains broad interests as well as particularized operations is the proper spawning ground for young scientific minds.

FEDERAL GOVERNMENT

The year 1937 marked the first significant participation by the federal government in cancer control. For some years previously the government had supported, as employees of the Public Health Service, a few investigators who worked entirely on fundamental problems in cancer in laboratories at Harvard and at the National Institute of Health. The Service had also provided a few annual fellowships in clinical cancer. The building of the National Cancer Institute was authorized in an appropriation of $750,000 and the structure at Bethesda, Maryland, was commissioned the following year. From then until 1946 the Institute received a yearly appropriation of $750,000 for operations confined almost wholly to basic investigation. Its work has been described in a monthly publication, the *Bulletin of the National Cancer Institute*. Two years ago the allocation to the Institute was increased to $1,700,000 and the program of the Institute was considerably broadened to include educational activities. The number of clinical fellowships was increased and projects in lay education were undertaken through exhibits, pamphlets and films. In 1947 the Congress made available for the expanding interests of the Institute the sum of $14,000,000. This supports, in addition to th intramural laboratory research, a program of grant in-aid to other investigators, clinical and researc fellowships in cancer, grants to the medical schoo to encourage improvement and integration undergraduate cancer teaching, special project gran to institutions and official health agencies, an educ tional program developed with the institute, ar grants to each state government for promoting co trol programs locally. In addition to this $14,000,0 budget, $8,000,000 was provided for the constru tion of new cancer research facilities.

The phenomenal surge in the Federal Gover ment's interest in cancer is, I am sure, the forerunn of greater things to come. The program has bee well planned and competently directed. The volu tary health agency and, I would hope, organize medicine welcome the participation of the gover ment for its resources are essential to the solutio of the many problems of cancer, biological, clinic and economic.

It is with admitted prejudice that I point no toward the fact that this rapid expansion of th government's activity in cancer control followe quickly upon the broadening of the base of oper tions of the voluntary health agency. This is th same pattern which was drawn some 25 or 30 yea ago when, undoubtedly due to the efforts of th National Tuberculosis Association, government (i this instance the emphasis was on the state) assume its responsibility in the control of tuberculosis b providing sanatoria, chest examinations for famili of known tuberculosis patients and free sputu studies. This, after all, is the destiny of the voluntar health agency—to lead, to motivate, to mobilize th resources necessary to combat the menaces to th public's health.

The American Society for the Control of Cance had continued without interruption its work of la education, begun in 1913 with the publication of a informational article in a nationally known popula magazine. In 1921 the first educational motion pic ture film for laymen was produced. Bulletin pamphlets, posters, exhibits were prepared an widely distributed. Cancer education in high school and colleges was promoted. Talks on cancer befor club groups, civic assemblies and church organiza tions were provided. The work extended, as fund became available, to volunteer aid to cancer patients Dressings were made and distributed to cance patients; transportation to and from the hospital o

octor's office was offered; financial and even per-nal home assistance to needy patients was estab-hed in many of the Society's units; service facil-es such as cancer clinics and diagnostic clinics ere supplied with needed diagnostic equipment and ray therapy machines and radium. Annual appeals r funds were intensified. In 1944 the April cam-ign of the Society raised $800,000; in 1945, ,000,000; in 1946, $10,000,000; and in 1947, $12,-5,000. In 1945 the corporate name of the American ociety for the Control of Cancer was changed to e American Cancer Society. It was reorganized to clude on its Board of Directors equal professional d lay representation elected by the 59 Chartered ivisions of the Society. With the increased funds ailable following the campaign in 1945 it became ossible for the first time to increase the support of search in the program without lessening by one ollar previous service to patients and educational forts.

A grant-in-aid and fellowship program was insti-ted; its administration called for the establishment a group of the country's leading scientists repre-nting virtually every scientific discipline, which ould serve to weigh the merits of requests for re-arch grants and fellowships and make recom-endations for their support by the Society. This roup, the Committee on Growth, now consists of 6 members and 21 advisory panels with a member-ip of 120. It is actually a committee of the Na-onal Research Council. All members serve without ay. The Committee has recommended and the ociety has extended 246 grants-in-aid to individual vestigators and 100 fellowships to young scientists f promise providing advanced technical training in ighly particularized areas of interest. In the nearly ree years of operation of the Society's research rogram $6,000,000 has been appropriated for re-arch purposes. In addition to the grant-in-aid and llowship program administered by the Committee n Growth, the Society has awarded institutional r mass research grants to 15 institutions for the evelopment and operation of new cancer research.

The Committee has further conducted symposia n certain subjects of research interests such as utrition. The Committee has served to spend the oney contributed by a generous public wisely and, e are satisfied, in avenues offering the greatest romise of fruition. It has done more, it has defined he areas of growth phenomena in greatest need of lumination. And further, it has established a pattern of control of funds for research as devoid of partisanship, political interests and sectionalism as can be looked for from human beings.

Here, then, is the gestational record of cancer control. *What is the patient's present condition?* The laboratory research chart records a collar count per year of about $14,000,000; the differential is $8,000,000 from the federal government; $3,000,000 from the American Cancer Society; an estimated $3,000,000 from state governments, foundations, private philanthropy and university budgets.

The clinical chart, covering the educational system, the reporting system, support and development of clinical facilities, ecological (or epidemiological) studies, and the care of the hopelessly ill indicates $6,000,000 from the federal government, $9,000,000 from the American Cancer Society and about $2,500,000 from state governments and other sources—a total of $17,500,000. To put it more generally, federal and state governments, the voluntary health agency and miscellaneous sources are providing at least $31,500,000 per year for cancer control. This figure represents an annual cancer budget about 14 times greater than that of 4 years ago. And yet in the light of the enormity of the challenge it seems pitifully small.

What is the rate of the patient's metabolism today?

RESEARCH

The basic investigations in the sphere of cancer are moving forward at a speed never known before. The extent of the problem is charted—roughly, it is true. At least it is apprehended sufficiently to indicate that cancer is no longer the responsibility of the surgeon, or the radiologist and the pathologist only. We now know that the understanding of its essential nature requires the combined operations of physicists, chemists, physiologists, biologists, botanists, geneticists, endocrinologists. It is hard to imagine what scientific interest is not now called on to study one or another facet of cancer's surface.

EDUCATION

The official and especially the voluntary health agencies (with the help, let us acknowledge, of industry and insurance companies) are increasing the momentum of education of lay persons with respect to cancer prevalence, its early signs and the importance of early diagnosis. Pamphlets, exhibits, posters, motion picture films, the radio, newspapers and magazines are regularly employed in an effort

to create an intelligent, forewarned, forearmed public. I am unimpressed by the argument of those who maintain that current cancer publicity frightens people and creates cancerophobia. I recognize that it may be the proximate cause of such psychoneurotic states. But I also recognize that there are many who are destined by heredity or past experience to develop such attitudes of mind. If it is not about cancer it will be about almost anything handy, insanity, heart disease or pregnancy. And I cannot feel that we are justified in tempering our call to alert in deference to congenital non-combatants. I challenge denial of the truth of our cancer educational material, and I stand by the general soundness of acquainting all persons with the enemy's code.

There is some evidence that education of the public is not a will-o'-the-wisp. A recent study has shown that in one community the percentage of patients guilty of culpable delay before consulting a doctor has dropped from 44.3 per cent in 1938 to 32.0 per cent in 1947. Yet during that same period the percentage of doctors responsible for culpable delay in diagnosis rose from 17.0 in 1938 to 27.8 in 1947. On this basis it would appear that doctors are falling behind their patients so far as early diagnosis goes.

PROFESSIONAL EDUCATION

Certainly the best place to teach doctors to recognize cancer is in the medical school. In the past cancer has been presented to the student piecemeal and according to the whim and personal interests of individual faculty members. In an attempt to integrate the presentation of cancer to the medical undergraduate, the National Cancer Institute has offered grants of from $10,000 to $25,000 per year to each medical school for the purpose of improving cancer teaching. To date 42 schools have accepted such grants and 21 others state that they are currently preparing teaching plans in order to utilize grants effectively. It is a truly remarkable tribute to Yale University School of Medicine that its foresight in the early acceptance of the cancer teaching grant and its exemplary plan for coordinating the teaching of cancer has provided signal leadership in this important development.

Discussion of postgraduate training in cancer diagnosis and treatment could, if there were time, bring us face to face with the questions of the cancer specialist. We shall say no more about it than to remind you that there are those who say with the Irishman viewing a giraffe for the first time in his life: "There ain't no such animal." The fact is th there is a respectable number of men with gener training in clinical cancer who are now occupyin positions of leadership in clinics, institutes, medic schools and private practice, and these confined t cancer. The National Cancer Institute is currentl supporting 76 fellowships in cancer—some of th general type, others in surgery, radiology an pathology—in some 26 different institutions. Th American Cancer Society on July 1 has mad twenty additional clinical cancer fellowships avai able. To train 100 each year to develop speci interest and competence in the diagnosis and treat ment of cancer is not extraordinary. There are wid reaches of our country, as I shall show in a momen where no adequate cancer facilities exist, becaus there are not the men to operate them.

For the physician in practice, refresher courses i cancer are held in 23 states annually. These var from one to four days, and they are uniformly we attended. The American Cancer Society and th National Cancer Institute are producing jointly series of six motion picture films in color for use i county medical society meetings, illustrating tech niques in the diagnosis of cancer. The America Cancer Society has, in addition, a library of extan professional films dealing with cancer for loan t interested groups. In progress is a large library o kodachrome slides illustrating many varieties o early cancer, to assist doctors in illustrating lecture to professional societies, hospital staffs and nurses A new journal, *Cancer*, edited by Dr. F. W. Stewar and an advisory editorial board of 51 leading clin icians, investigators and public health officers ap peared in April. These efforts are directed toward keeping the busy practitioner abreast of our ad vancing frontier of cancer knowledge.

FACILITIES

There are in the country 324 independent service providing accurate information regarding cance and serving, under the guidance of local medica societies, to direct enquirers to proper medical facil ities. One hundred ninety cancer detection center are operating to examine presumably well persons i order to uncover unsuspected cancer. The numbe of cancers discovered in such centers is in the orde of 0.5 per cent. Whether they can become a gener ally useful addition to the forces of cancer control i not yet determinable. More experience in more clinics will be necessary to answer the many ques tions which Detection Centers have raised.

The American College of Surgeons now approves 92 cancer clinics and 32 cancer diagnostic clinics. New Hampshire leads in proportion of clinics to population, with 1 for each 45,000 persons. Connecticut is second, having 1 cancer clinic for each 9,000 population. If we were to regard 1 clinic per 50,000 of population as a desirable proportion, we should require in this country as a whole 6 times as many as now exist. The distribution of clinics varies greatly. Oklahoma has 1 per 2,336,000, and 6 states have none at all. General hospital beds are also distributed unevenly varying from 150 per 100,000 population in Mississippi to 530 in California and 520 in Massachusetts.

EPORTING

Twenty-five states have statutes providing for cancer case reporting under legal warrant. In only one does it appear to approach 75 per cent success. Two states have recognizably effective registries for cancer morbidity—California and Connecticut. The Connecticut system appears to be most effective of all, and I wish there were 47 more Eleanor MacDonalds to make this remarkable achievement possible for every state. Wide differences in cancer mortality by states exist from 182.9 per 100,000 in New York to 65.9 per 100,000 in South Carolina. These differences may be attributable to variations in standards and availability of medical care, or they may require careful ecologic studies to explain them. Twenty-four states offer some type of financial assistance to clinical facilities, as a rule limited to aid to indigent patients. Twenty-three states have arrangements with pathologists for providing tissue diagnostic service. In 6 of these states this service is without cost to the patients regardless of ability to pay.

In retrospect our patient's condition is not good, but neither is it hopeless. One thing seems to be *sure*, his prospects are better than they were even 4 years ago. What is the indicated prescription? I think it is not so much a matter of changing the ingredients as it is of increasing the dose. $14,000,000 per year for research is surely homeopathic. Suppose, for example, that we could be assured of discovering the causes of cancer and methods of preventing it if we spent $2 billion in research, which is what it cost to make the first atomic bomb. At our present rate of spending we would have the answer in 142 years. But most of us feel that the ultimate secrets of cancer will prove vastly more elusive than the secret of the atom.

Education of lay persons and, more important, of doctors must be intensified many fold until every adult man and woman in the country is intelligently aware of the early signs of cancer and of the need for early treatment. More and better facilities must be provided—hospital beds, clinics, facilities for the terminally ill—so that adequate medical care is available and freely accessible to every cancer patient.

Epidemiological studies must be undertaken on a broad scale. We must learn whether it is true, as we suspect, that cancer of the stomach is less frequent in our South than in the North; whether certain anatomical varieties of cancer have heritable factors; whether orthodox Mormons have little cancer; whether smoking causes cancer of the lung; whether the atmosphere of Bridgeport is cancerogenic as compared with that of Santa Fe; why orthodox Jewish females are relatively insusceptible to cancer of the uterine cervix. Cancer must be reported everywhere as effectively as it is here in Connecticut, in order that we may plan our service programs intelligently and measure the effectiveness of our control efforts.

We can be heartened by the progress we have made in a single generation; we cannot fail to be challenged by the long road ahead.

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THE SOCIAL IMPACT OF ALCOHOLISM

Selden D. Bacon, ph.d., *New Haven*

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Discussion of the problems of alcoholism has always been accompanied by violent emotion, by the choosing of sides, and by raucous fighting between those sides. Although both Wets and Drys achieved notable victories over each other, until the last few years nothing of a constructive nature was achieved which would alleviate, mitigate, or prevent the many problems associated with beverage alcohol; neither the Wets nor the Drys had anything to do with this recent progress. The great majority of the public has long reacted as if it wished a plague on both houses; they wished this not only because of the antics and the sterile programs of the two groups, but also because of the pall of ignorance, misinformation, and fallacious folk lore which literally smothered this great problem area. The vast majority of physicians were to be found with the majority of the population; the less they saw or heard about problems of alcohol and alcoholism the happier they were.

However, there was a problem and its manifestations continued. And so people reacted just as they have reacted throughout time immemorial to difficult, painful, continuing problems for which there was no answer. What did they do? They pretended that there wasn't any problem. They tried to laugh it off, drunkenness was funny, drunks were the subjects of jokes and laughter at home, in the club, on the stage, and in literature. Another reaction was to punish the people and destroy the things most obviously connected with the problem. And so drunks were whipped and fined and imprisoned. Taverns and saloons were attacked with axes and ordinances. Liquor advertising was attacked with counter advertising and legislation. People tried to hide the problem, they hid it by putting the drunks in jails, they hid it by giving it fancy names, sometimes using medical polysyllables. People prayed that the problems would go away. They swore at the problems. They even passed laws which announced that there should be no problem.

All these are common reactions to social problems which are painful, which are continuing, and for which there is no answer. Most diseases have been responded to in these ways. Venereal diseases have only recently come part way out of this development. Mental diseases are still in large part in this stage of development. Municipal corruption and strikes and bad housing have all been responded to in similar fashion, to say nothing of war, poverty, and the types of behavior called crime.

Before describing the social impact of alcoholism it is important to realize the social attitudes and customs which surround the point of impact. Whether it is right and proper, whether we like it or not, these primitive and ineffectual responses form the social setting in which the manifestations of the problem are embedded. These are the habits and attitudes which affect all of us. This is the mental and social and emotional equipment which all of us possess and share, whether we want to or

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not, whether we are physicians or policemen or mechanics or farmers.

The problems continue and so we try to meet them anew. Now, however, we have some new equipment. The first new tool we possess is new only in its relation to the field of alcohol problems, elsewhere it is as old as the hills and taken completely for granted. It is called definition of the problem. There are many problems connected with alcohol—traffic problems, legal problems, economic problems, religious problems and so forth. Today, one of these problems is selected for discussion—alcoholism, and definition of this one of the many problems of alcohol is called for. A tentative, working definition will be presented which will mark out the category of persons who are affected. They will be subdivided into three groups. The classification is descriptive or demographic, is not intended to be an etiological categorization. The first group labeled "chronic excessive drinkers," includes people who possess two characteristics, one dealing with drinking, the other dealing with a clinical picture of their adjustment to life.

This clinical picture can be gained by a study of the individual's life, especially its current status, a study which could be made by any tolerably intelligent lay person. Individuals in this category are likely to be in poor physical condition—poor physical condition which is associated with their continual and heavy use of alcohol. They lead an irregular life, they have poor sleeping habits, poor eating habits, they are highly susceptible to all sorts of accidents and diseases, they operate under considerable emotional tension. These physical conditions do not result from the action of alcohol on cell structure, but from the ill-organized, uncertain, and unsatisfying way of life which is manifested by these individuals.

Most individuals in this category show a badly maladjusted psychological structure. Description of those who do not will be postponed until a later moment. This maladjustment is manifested by their feelings of guilt, inferiority, and remorse, by their chronic frustration and by their dissatisfaction with their life and their drinking. These painful sensations are very deep, but are often hidden from friends, family, and doctor because of the aggressive, silly, pain-provoking, though perhaps well-intentioned responses which usually follow when the pain is admitted.

This psychological maladjustment is manifested in the frightfully egocentric world in which so many of these individuals live, in their extreme self-consciousness, in their self-pity, in their failure to adapt to other people or to objective reality.

This psychological maladjustment is seen in their almost childish rationalization, their dependence, their juvenile mood swings, their immature idealism. Dr. Tiebout will discuss the structure and etiology of this aspect in far greater detail.

A third aspect of this clinical picture is of a social nature. Characteristically these individuals are under-socialized or de-socialized. Socialization may be viewed in terms of attitudes, activities, and group-membership. This chronic excessive drinker can be marked off from the rest of the population by his deviation in attitude: first, his lack of attitude about so many, many subjects; his disinterest in anything except himself and his drinking; his ever so superficial comment or belief concerning almost any objective matter, beliefs and comments which can run to wildly irrelevant and undisciplined extremes of cynicism or of idealism. In activities, many of these alcoholics spend much of their time doing what the rest of us call "nothing." When they do engage in usual social activities, they are sporadic, careless, ineffective, and, again, utterly undisciplined. They may rove from job to job, from hobby to hobby. To speak in sociological terms, the society presents many patterns of behavior—economic, religious, sexual, recreational, artistic, and so on—but the alcoholic does not activate these patterns.

Finally, group membership. Characteristically the alcoholic is not married. Or, if married, is separated, divorced, or widowed. Characteristically, the alcoholic has lost contact with his parental family or, if contact is maintained, it is parasitic or stormy. The alcoholic does not have friendship cliques. The alcoholic again and again shows a history of moving from job to job, from residence to residence, from town to town, this mobility practically insuring against realistic membership in any group.

All of the alcoholic's maladjustments are in a way related to this lack of membership in close, emotionally-meaningful groups. For it is through such groups that the emotional needs of life are satisfied. It is in friendship and family that needs for recognition, emotional security, affection, sexual release, and all manner of protection are satisfied.

No wonder the isolated man is unhappy. It is in such groups that the stimulus to activity, attitude, and interpersonal relationship is located. No wonder that the isolated man has few interests and does very little if anything. It is from such groups that realistic rewards for acceptable activity and realistic punishments and discipline for deviant behavior and attitude arise. No wonder that the isolated man has sophomoric ideals, non-activity, childish cynicism, fantastic self-pity or self-praise. The isolated individual will of necessity be insecure, unhappy, suspicious of others, and different from others. Furthermore, isolation leads to more isolation; the longer it lasts, the harder it is to break.

The second major aspect of these chronic excessive drinkers concerns their reaction to drinking. They react to alcohol differently than do ordinary social drinkers: they have blackouts; once started drinking, they take more drinks than their fellows, often secretively; they develop rationalization systems for drinking far beyond the ordinary pattern; morning and solitary drinking commence; and then that strange socio-psychological pattern called the bender.

In their social and psychological maladjustment and in their anomalous reactions to drinking and while drinking, members of the category "Chronic Excessive Drinker" are not "just a little different" from others. They come to be qualitatively different so that there is not too much question in the mind of a trained therapist as to whether he is or is not faced with a member of the chronic excessive drinking brotherhood. Some individuals are heavy drinkers and have problems, but that doesn't make them alcoholics. Many persons have gotten drunk once or twice. Some people may have had one blackout. It is the development of a pattern that indicates membership in this category. There is no one pattern and, as the situation is progressive and as friends, fellow workers and family members usually join in an unconscious conspiracy to hide the condition during early stages, it is not easy to see what is happening unless the facts are available. In this country there are probably about a million and a half to two million chronic excessive drinkers.

Members of the second subdivision of the alcoholic population may be called the compulsive drinkers. The word "compulsive" is used in a general, not in a specific psychiatric sense, although some alcoholics are undoubtedly compulsive in the psychiatric meaning. Members of this category have the physical, psychological, and social maladjustments already described. They have the unique responses to drinking. Most of them in fact have gone further in these phases: they may have started to "do something" about their drinking; they have tried going on the wagon; they are attempting new systems of drinking, either kinds of drinks, or times for drinking, or companions; they have developed excessive fears related to their drinking.

The added characteristic which marks them off from the chronic excessive drinker concerns motive and control. Some chronic excessive drinkers still get some pleasure from drinking, are still drinking in part because of social conventions, still can stop short of benders under some circumstances. Except for temporary "dry" periods whose endurance is not wholly within his direction, the compulsive drinker has lost control and his motivation is one of existence. He doesn't like the taste, he doesn't like drinking, he curses himself and the bottle, but he winds up drunk. He means to take one, seriously intends to have just one, and ends up with a hundred. The line between the chronic excessive and the compulsive is shadowy, but there is in most cases an obvious difference. The chronic excessive may be developing a greater and greater reliance on alcohol as a personality crutch; it may be difficult to place him on March 15th, 1941; but it may also have been clear that he was not a compulsive drinker in 1938, but surely was in 1943. There are probably about a million to a million and a half compulsive drinkers.

The third subdivision of the alcoholic population is made up of the chronic alcoholics. For all practical purposes they have the social and psychological maladjustments, they have the unique responses to drinking; in fact, they may show a complete breakdown of rationalization system, show marked signs of hangover, tremors, and so on. Probably all of them are compulsive drinkers.

The additional characteristic which marks them off from the other two groups is the presence of a readily diagnosable disease, physical or mental, which is closely related to the action of alcohol on the body. They may have a psychosis, they may have marked liver damage, and so on. This is the group whose size can be stated with great confidence. There are about 750,000 chronic alcoholics. The three groups together make up about 3,750,000. This estimate for the total alcoholic population errs

if anything on the conservative side.

Who are these alcoholics (referring to the total group)? Where do they come from? What sort of people are they? If something is to be done to reduce or alleviate or prevent a problem, such information is needed. Here are some of the answers. As to wealth, they come from the poorest families, from families of moderate means, from families of wealth, from families of multi-millionaires. The individuals themselves may have earned over $50,000 a year or have been usually indigent. The greatest number appearing at the Yale Plan and Connecticut Commission clinics have earned what are called average incomes. As to education, the entire range is again present. There are feeble minded, moron, and genius. It should be noticed that the incidence of feeblemindedness is considerably greater than it is in the general population. As to occupation, almost every occupation known has its representatives. Despite their mythical reputation, it is possible that bartenders show an incidence that is rather high. Naturally, in later stages of the condition the occupational standard is very low. Dishwashers, day-laborers, hospital attendants, and similar categories come to show abnormally high incidence. This does not mean that such positions are the occupational measure of the person during his economic career. As to region, all regions of the country, urban and rural, Wet and Dry, East and West, are represented. Since alcoholics tend to stick to the source of supply and to areas where their behavior is less obvious, there is a greater incidence of *current* address in the urban centers. Nevertheless, there are plenty of flourishing Alcoholics Anonymous groups in bone-dry, rural Kansas. As to nationality origin there are some differences. As the immigrant groups have been in the United States longer and have assimilated the dominant American culture pattern, however, the alcoholism rate tends to become similar to the domestic population. Mediterranean peoples tend to have lower rates; north western European groups tend to have higher rates. The Jewish group apparently has an amazingly low rate.

In relation to sex, a striking difference is to be found. The ratio is between 5 and 6 men to one woman. This difference is almost certainly to be explained in largest part because of cultural forces. In other societies the ratio has been very different; for a while in England the ratio was only 2 men to one woman. In Scandinavia it was about 23 men to one woman. In our society the sanctions against drunkenness in women are so severe that it is an unlikely symptom to be selected from the other neurotic patterns, some of which would seem to be almost socially approved for women. Chronic drunkenness in women is so socially taboo in almost all strata of our society that it is not surprising that our clinics report that alcoholic women are usually far sicker persons than the average of the men.

An even more striking difference than that shown by sex is that of age. Alcoholism is by and large a condition of middle age. More than 85 per cent of the cases are in the age range 30 to 60. It should be pointed out that alcoholism is a progressive condition, that it may be ten years or more from the first indications of an alcoholic reaction to drinking until the social and psychological disturbance is so pronounced that the individual is clearly in the alcoholic category. A few individuals who show abnormal reactions in their first drinking experiences, would appear to be compulsive drinkers almost immediately. In such instances it is more than likely that the individual is close to psychosis and that alcohol played an insignificant role in the etiology of his condition.

With this much of a description of the category of persons involved it is possible to speak of the social impact of the problem. First let me return to the opening subject, the setting of belief within which the impact occurs. The belief has utterly failed to distinguish between drinking and drunkenness, between alcohol and alcoholism. Beliefs are prevalent that alcohol is a poison, that alcoholism is inherited or, utterly incompatible, because of individual wilfulness; beliefs that only certain types of people from across the tracks are afflicted, that alcohol is a stimulant, that alcohol is the cause of alcoholism, and so on are quite common. Since this last belief still seems logical to many people, perhaps a brief comment is needed. There are approximately 65,000,000 persons in our country who drink alcohol beverages. No one has yet suggested that there are 65,000,000 or 33,000,000 or even 6,500,000 alcoholics in our society. Alcohol is a necessary factor in alcoholism; alone, however, it does not make alcoholics. About 6 per cent of the users are afflicted. A necessary factor or a pre-condition, however, is not a cause. The danger of such a mistaken belief is easy to see. It vastly oversimplifies the problem, and it suggests remedies which not

only fail to solve the problem but create new and additional problems.

Perhaps the first statement to make about the social impact of alcoholism is that it is hidden whenever possible and sometimes when it would seem to be impossible. Industry and death certificates present obvious examples of this hiding. The president of one of America's very famous industries has made the statement that alcoholism is an unknown phenomenon in his organization. To him it may be unknown. This particular president is a well-known man who enjoys his status as a philosopher and phrase maker, and he has certainly had a great business success. However, despite my very limited business connections I had the following experiences: the first member of Alcoholics Anonymous I ever met had been in this company's employ during the last five years of his alcoholism; this was in a branch office in Connecticut. Last week I was in the town where this business has a major plant. Through the National Committee for Education on Alcoholism an information center is maintained in that town to help alcoholics and to inform others who are interested on what can be done, what local facilities will help alcoholics, and so on. I sat at the desk with the secretary. The first call was from an alcoholic employed in that company. Those are two of the three employees I ever met from that organization. The local unit of Alcoholics Anonymous has plenty of members from that company. Why is it hidden from the president, from many industry presidents? It is hidden because of the stigma, because of the Wet-Dry dog-fight, because no one thinks that giving out the information will do any good, because until very recently nothing could be done to help. Workmen on the job protect their fellows; foremen don't care to report the problem because it would look bad for them, because it is a moral issue and none of the company's business. Personnel and health officers enter colds, nervousness, fatigue, broken arms, family troubles, and transportation difficulties into the absentee records; they enter an awful lot of such comments on their Monday morning charts. Factory and store police and guards keep obviously drunken employees outside the gates. Techniques to protect corporation officers and technical men who are alcoholics are as simple as they are common. As a result, the president doesn't know about it. Believe it or not, some industrial medical officers seriously state that there is no problem in their plants. Actually, there are 1,300,000 men fairly regularly employed in industry who are alcoholics. This says nothing at all about others employed in industry who lose time, are occasionally inefficient, have accidents, and in general lose money for their companies because of occasional over-indulgence. The impact on industry is enormous, but it is hidden, denied, laughed at.

Death certificates are consistently modified so that stigma will not attach. On the rights and wrongs of this practice no comment is here required, but one result is clear—the role of alcoholism is hidden. It is hidden not only from distant friends of the family, but also from statisticians, physicians, and health authorities.

One more instance of hiding, quite unintentional: police arrests and court appearances. Aside from traffic cases, drunkenness is responsible for more arrests and court appearances than any other cause. However, most police departments allow local individuals two or three arrests and stays in the lock-up each year before the individual is brought into court. Even more important, if possible the policeman will not arrest the drunk or will take him home. Arrest and lock-up are for the dangerous, obnoxious, and unknown drunks. This may or may not be good police procedure, but one result is sure, it hides the nature and extent of the problem. To give you an idea of how misleading these official reports are, the New York Police Department annually reports fewer arrests of drunks than either Hartford or New Haven, and these two cities have a modest arrest policy. These arrest records, of course, are only a distorted reflection of alcoholism rates.

Two aspects of the impact of alcoholism on society will be described. The first might well be considered the most important social effect, but, strangely enough, it is rarely if ever mentioned by the warlike opponents of the Wets.

About 85 per cent of the total alcoholic population is male. The same percentage, by coincidence, is in the age-bracket 30 to 60 years of age. This means that about 2,890,000 men between 30 and 60 are alcoholics. The total male population 30-60 years of age is about 28,500,000. This age range has very important functions to play in our society. These are the men who are supposed to be heads of families, they are the group from which industrial, military, artistic, religious, educational, commercial, political, and neighborhood leadership

and responsible participation are supposed to come. This is the group in which maximum ability in profession or occupation is made manifest. In wartime this is the age range which is the backbone of industry and commerce. None of these 2,890,000 operate at 100 per cent efficiency; a few may be operating at 75 per cent, many at about 33 per cent; no small number are 10 per cent or more below zero; that is, they are an overall liability in terms of time, money, facilities, service, and emotional strain.

The loss of 10 per cent of the potential adult man power over 30 years of age reveals a social impact which is hard to equal in other fields. One of the reasons it is hard to equal is that the condition is chronic; these men and women are not afflicted at age 37 and then found well again at 39 or 43. Unless remedial steps are taken, they remain in the category until they die.

The other aspect of social impact can be mentioned with only a few words. What does the society expend, how does the society react to this loss? The society maintains about 5,000 lock-ups, jails, poorhouses and perhaps a 1,000 so-called shelters to take care of the poorest and most obnoxious of these people. The shelters show about 80 to 95 per cent of their population to be in this alcoholic category. The jails show from 60 to 80 per cent of their total population in this category. Aside from traffic cases, the major job of our lower courts and of our police departments is with the drunkard. What percentage of welfare and social agency cases are directly related, what percentage indirectly related to this alcoholic population is unknown because it is so carefully hidden. The answer to the problem is above all of two sorts: one, an enormous expenditure of money; two, emotional disruption and sorrow.

Two comments on this awful waste and on the financial and emotional reaction. First, a large part of the waste is unnecessary. Second, the financial and emotional outlay is utterly ineffective. Today we have available ways and means to alleviate the problem, to rehabilitate, and to inaugurate prevention. Nor are these ways and means expensive, esoteric, or incompatible with American customs and behavior.

Description of one group of the chronic excessive drinkers was postponed. This group is made up of men who do not seem to feel the pain, the guilt, the remorse. They are apparently satisfied with the low level of existence they maintain. They are socially disorganized; psychologically they are perhaps not normal, but they are adjusted to a substandard existence; their reactions to alcohol are not normal, but they manage to avoid complete collapse. This group will be very difficult to cope with. They might be called the common drunk, are often found in missions and jails. The feebleminded members of the total alcoholic population will be difficult to cope with; their problem, however, is not alcoholism; it is feeblemindedness. The psychotic members of the total alcoholic population will be difficult to deal with; their problem is not alcoholism; it is psychosis. However, two thirds to three fourths of this total population is susceptible to rehabilitation. The job is partly a medical job, partly a psychiatric job; there are functions for the social worker, the recovered alcoholic, the psychologist, the vocational expert, and the minister. The job calls for cooperation by courts, hospitals, clinics, medical schools, and health and welfare agencies.

Above all, the job calls for public recognition, better public understanding, and finally public action. First we must have a more effective social setting of attitude and belief and knowledge within which the impact of the problem takes place. Then we can cease hiding and denying the problem. Then the technically qualified people with public stimulation and public approval can tackle this problem. We know that together they can meet it humanely and effectively. We know that they can achieve both rehabilitation and prevention. And we know that this can be done not in the dim and distant future, but that great strides can be taken, realistically and effectively, in our time.

THE EFFECTS OF CURARE AND PROSTIGMINE ON THE CENTRAL NERVOUS SYSTEM

Preliminary Report of Clinical Observations

SIDNEY BERMAN, M.D., *New Haven*

CURARE is best known for its paralyzing action on the myoneural junction in skeletal muscle. Prostigmine, the customary antagonist of curare, enhances neuromuscular transmission by means of its anti-cholinesterase properties and by direct cholinergic-like stimulation of the effector muscle cell.[21] Recent experimental evidence suggests that curare and prostigmine have depressant effects on the central nervous system, most clearly demonstrated in laboratory animals, in addition to, and independent of, their mutually antagonistic peripheral effects in muscle.

Does curare have a depressant action on the human central nervous system? This clinical study, reporting neurological observations of a drug action on humans was an attempt to help answer this question. In view of the mounting interest in the therapeutic applications of curare, as for example, in poliomyelitis, spasticity, tetanus, shock therapy,[1] and anesthesia,[6,26] the author deems it important to present the findings of early clinical observations regarding the central effects of curare on humans.

METHOD OF STUDY

A total of 20 neurologic and 1 psychiatric patient were selected for investigation (Table 1). Of this group of 21 patients, 14 demonstrated spasticity and 2 (general paresis and obsessive-compulsive reaction) were neurologically normal on clinical examination.

DRUGS AND DOSAGE

19 patients received a course of prostigmine injections alone, 18 received curare alone, and, finally, 14 received prostigmine and curare in combination. The injections were given 3-4 hours after arising in the morning following which both ambulatory and bed patients were encouraged to resume their usual activities. Prostigmine methyl sulfate, 1.0 mg. was injected subcutaneously. Intocostrin,* a water soluble, purified tube curare in which the active alkaloid is tubo-curarine chloride, was injected intramuscularly in doses ranging from 0.6 mg. per kilogram to 1.0 mg. per kilogram and in some cases up to 1.5 mg. per kilogram.

TABLE 1

TYPE OF CASES TREATED

DIAGNOSIS	NUMBER CASES	OTHER NEUROLOGIC ABNORMALITIES (REFLEXES AND CLONUS)	SPASTICITY
Multiple sclerosis	4	4	4
Primary lateral sclerosis	4	4	4
Friedreich's ataxia	1	1	1
Post traumatic athetosis	1	1	1
Amyotrophic lateral sclerosis	1	1	1
Hematomyelia (Post-traumatic)	1	1	1
Spinal cord tumors	2	1	1
Acute poliomyelitis	1	1 (depression)	0
Subacute poliomyelitis	1	1 (depression)	0
Sciatica, chronic	1	1 (depression)	0
General paresis	1	0	0
Obsessive-compulsive reaction	1	0	0
Dystonia musculorum deformans	1	1	1
Post-operative removal of meningioma	1	1	0

By means of frequent neurologic examinations, data were obtained regarding the status of the deep reflexes, spasticity, and clonus. In addition, the patients were carefully observed for the appearance of other manifestations.

*Intocostrin supplied by the Squibb Company

From the Neurological Service of Dr. I. S. Wechsler, The Mount Sinai Hospital, New York

The author gratefully acknowledges the invaluable aid of Dr. Stanley J. Sarnoff, with whom the original idea was worked out, and of Dr. Ernst Pick, Dr. Joseph H. Globus, and Dr. I. S. Wechsler for their inspirational encouragement, kindness, and suggestions.

RESULTS

Early effects refer to neurologic changes noted usually during the first hour after injection, but technically included changes up to 24 hours later. Late or protracted effect was demonstrated after 24 hours and up to 2 to 3 days after injection. The changes observed consisted of an increase in reflexes, spasticity, and clonus (augmentation effect) or a decrease in these phenomena (diminution effect). The three manifestations of hyperactivity changed singly, or in combination, and not to similar degrees. Reflex changes and clonus measurements were most sensitive in response, and these varied with each patient. In general, function varied inversely with spasticity; as spasticity decreased, voluntary motor power increased.

PROSTIGMINE EFFECTS

Of the 19 patients injected with prostigmine alone, 9 demonstrated an early effect, 8 showing the early augmentation effect and 1 the early diminution effect. Of the 10 patients showing no early effect, 3 had a protracted effect and 3 subsequently revealed a synergic central action in combination with curare. Thus, 15 of 19 patients showed neurologic changes. 5 patients exhibited the protracted effect (anti-spastic). In 1 case, the anti-spastic effect lasted as long as 63 hours. There is no adequate pharmacologic evidence to explain this on the basis of the traditional peripheral mechanism. The prostigmine group of 19 patients was considered the control for the curare group, inasmuch as the injections were given in the same manner and no instances of the sedative effect were noted.

SEDATIVE EFFECT

Of the 19 patients receiving curare alone or in combination with prostigmine, 16 demonstrated a sedative effect, 5 patients fell asleep, 8 complained of drowsiness or sleepiness, and 3 complained of dizziness. Only 3 of the 19 patients failed to demonstrate a sedative response. This sporific or sedative effect of curare was noted in the middle of the normal morning ward routine, 3 to 4 hours after arising.

CURARE EFFECTS

Of the 18 patients who received curare alone, 13 exhibited the early effect, 9 in the form of augmentation and 4 in the form of diminution. The 5 remaining patients showing no early neurologic effects demonstrated the "sedative effect."

Even with the small doses of curare used, a protracted effect of depression of reflexes, clonus, and spasticity was noted in 5 of the 18 patients. This late curare action was demonstrated by a decrease in spasticity lasting an average of 2-3 days. In one patient with multiple sclerosis, the muscle relaxation was noted to last as long as 6-7 days. In general, function varied inversely with spasticity; as spasticity decreased, voluntary power increased. 4 of the 5 patients showing the protracted effect exhibited, on earlier neurologic testing, the typical early augmentation effect.

Curare administration* caused therapeutic relaxation of spasticity (protracted effect) in 2 cases of multiple sclerosis, one of cervical hematomyelia (post-traumatic), 1 of Friedreich's ataxia, and 1 of dystonia musculorum deformans.

CURARE-PLUS-PROSTIGMINE, COMBINATION EFFECT

14 patients were given a simultaneous intramuscular injection of 1 mg. prostigmine plus 60 mg. curare after 12 of the 14 had previously received both curare and prostigmine alone. One patient had received only prostigmine previous to the combination, and the other just curare. The early augmentation effect was noted in 10 out of 14, and the early diminution effect in 3. Five patients demonstrated the protracted effect.

DISCUSSION

Observation of the neurological effects of curare (without prostigmine) provides insight into a more complicated pharmacologic action in humans than was previously realized, supporting the recent experimental evidence of a central depressant action of curare on the central nervous system. Pick and Feitelberg[9] in their experiments with frogs demonstrated a gradual disappearance of the alpha waves in the electroencephalogram after the injection of curare into the ventral lymph sac, pointing thereby to a central depressant action of curare. Prolonged muscular relaxation in dystonic and spastic patients treated with curare was noted by Burman[3,4,5] and West,[25,26] the latter postulating a direct effect on the

*After this study was completed (and while in the military service), the author used the combination of curare and prostigmine in the treatment of 1 patient with multiple sclerosis, 1 with a post-traumatic cervical myelopathy (marked pyramidal spasticity), 2 with Parkinsonian rigidity, and 1 with hemiplegia following cerebral thrombosis. In all patients a safe and effective relaxation of spasticity and a corresponding increase in voluntary motor power was observed.

central nervous system, the so-called "lissive" action of curare. McIntyre, et al,[18] noted electroencephalographic changes in dogs after intravenous injection of d-tubocurarine (the purified crystalline active curare principle in Intocostrin). The initial transient effect was an increased frequency and voltage almost simultaneously in the occipital, parietal, and frontal leads, immediately followed by a prolonged depression of electrical activity, especially of the frontal areas. It was noted by these investigators that the depression of frontal areas occurs before peripheral paralysis. Pick and Unna[20] observed that prostigmine failed to influence the depressant effect of curare and curare-like substances on frog brains, although it counteracted the peripheral effects of these alkaloids on the neuro-muscular junction. Schweitzer, Stedman, and Wright[22] in experiments on cats, and Kabat and Knapp[10] in clinical observations on humans also emphasized the central effects of prostigmine. Our results suggest that the peripheral paralytic depressant action of curare takes place either very early or not at all. The central depressant action has both an early and a late phase. Obviously, during the early phase, both peripheral and central actions are proceeding simultaneously.

In addition, the question of dosage and initial muscle tonus are fundamental. Generally speaking, the larger doses increased the peripheral paralytic effect, but the most pronounced states of muscle tension offered the greatest protection against this. Patients with the most marked spasticity could be given the maximum clinical doses of curare with impunity. Thus, the final effect of curare in a given patient was the resultant of all these divergent forces. In half of the cases, the resultant appeared to be a central depressant action, as evidenced by the augmentation phenomena (release of inhibition) of increased reflexes, clonus, or spasticity. The peripheral paralytic effect manifests itself as a diminution in reflex activity and cannot adequately explain this observed augmentation effect of curare. It is significant that these effects were obtained mainly with 0.6 to 1 mg. per kilogram, which are relatively small doses.

Even with these small doses of curare, a protracted depressant effect was noted in 5 patients. Four of these also showed the early augmentation effect which tends to favor the hypothesis that both phases of action of curare are qualitatively similar, merely expressing different time relationships in a central depressant mechanism. Further analysis of the dosage problem reveals that, with 1 mg. per kilogram intramuscularly, there was not a single instance of early muscular weakness, and the only respiratory depression occurred in an advanced amyotrophic lateral sclerosis patient showing marked muscular atrophy. Thus, for all practical purposes, none of the 18 patients showed a substantial peripheral, i.e., paralytic, type of response as manifested even in its earliest phase as muscular or respiratory weakness. Of course, the "early diminution" response occurred in 4 patients. This might be considered an objective neurologic manifestation of the peripheral curare action. However, it is significant that half of the total group of patients demonstrated the predominance of the central depressant activity during the early effect as shown by an augmentation of reflex activity.

It is also significant that the largest number of patients free of spasticity fall into the group of 13 patients in whom no protracted effect at all was demonstrated. This, in effect, increases the validity of the positive finding (i.e., the late relaxation), since, in general the more the neuro-muscular system approached the normal (i.e., the less the spasticity), the less chance there was for the curare to cause a late relaxation.

One of the most important observations concerns the effect of curare on 2 patients with normal reflexes, 1 a mild paretic and the other an obsessive-compulsive neurotic. In the case of the paretic, there was no effect on reflex activity, but he demonstrated the sedative effect. The obsessive-compulsive patient demonstrated the early augmentation and the sedative effect. Following the curare injection, this patient felt dizzy, drowsy, and mentally slowed. Examination 1 hour post-injection revealed a slight decrease in reflexes. Examination 2 and ¾ hours later revealed the reflexes to be slightly livelier than the pre-injection level, and a bilateral transient ankle clonus was noted. This patient appears to illustrate all the early effects of curare proceeding simultaneously. At first, even though drowsiness indicated a central depressant effect, the peripheral action was predominant, and the reflexes were diminished. Later the release phenomenon occurred, as manifested by the appearance for the first time, of a bilateral unsustained ankle clonus. According to our present concepts, there is no way of explaining the ankle clonus as a peripheral curare effect, but it might be interpreted as a release phenomenon in a central depressant mechanism.

Thus far we have seen that prostigmine and curare when administered separately, each reveals simultaneous peripheral and central effects, the composite result on reflex activity being dependent on the predominance of one or the other effect. Traditionally, prostigmine is the antidote for curare poisoning and is used as such in anesthesia and other fields. However, from a theoretical viewpoint, we felt that while the peripheral actions were antagonistic, the central effects might be synergic. 14 patients were treated with the simultaneous intramuscular injection of 1 mg. of prostigmine plus 60 mg. of curare. In general, the results parallel those noted for each separately, except for a few significant trends. Thus, 77 per cent (10 of 14) showed the early augmentation effect with the combination, as compared with 50 per cent (9 of 18) for curare alone, and 42 per cent (8 of 19) for prostigmine alone. This appears to be statistically significant evidence in favor of a synergic action of both drugs in causing a central depressant release phenomenon. Despite this well known peripheral antagonism, the same 5 patients showing a delayed relaxation effect with curare alone, were again seen to give a similar result with the combination of prostigmine and curare. The relaxation lasted for approximately the same period, and in one case definitely lasted longer. In 3 patients, whereas a small dose of either drug alone caused no response, the same doses given in combination demonstrated a typical early augmentation effect. In another patient, curare alone caused the appearance of a transient ankle clonus which was demonstrable for 4 hours, while with the combination of curare and prostigmine, a transient ankle clonus appeared which was demonstrable for 27 hours. The above observations, in addition to the fact that not one instance was noted of prostigmine neutralizing the apparent central effects of curare, strongly suggest a central synergic mechanism. Thus, because of the additional safety factor and his apparent central synergy, we feel it advisable to use prostigmine routinely in curare therapy where the central depressant action is desired.

On the basis of the foregoing observations, we have entertained the hypothesis that curare has a central action, probably depressant, and that curare and prostigmine have a central synergic action. Many points are controversial. Complicating factors are the ocular muscle imbalance (diplopia, dizziness, blurred vision), heaviness of the lids (probably ptosis), and muscular relaxation. The extent of the peripheral curare effect on proprioceptive impulses and the possible relation to an apparent central action are extremely difficult to evaluate. If curare acts by blocking the central synapse, as well as the peripheral one, new light will be thrown on the central synaptic transmission mechanism. Confirmatory and basic neurophysiological studies now in progress will be needed to prove the hypothesis of a central depressant action of curare.

Discussing clinical observations on the use of curare in anesthesia, Whitacre and Fisher[27] described 2 cases in which a dose of curare sufficient to cause complete paralysis of skeletal muscles resulted in abrupt loss of consciousness without any preceding period of analgesia. There was no clinical evidence of hypoxia. The patients remained "anesthetized" for the duration of the operation. These authors also observed that "muscular twitchings and spasm" sometimes occurred during the recovery period following large doses of curare (given intravenously in anesthesia). Another pertinent observation revealed that if sufficient cyclopropane was given, subsequent curare might cause "spasm of the muscles." These interesting observations from the field of anesthesiology argue for the hypothesis of a central action of curare. The loss of consciousness and complete anesthesia achieved with the use of curare as the sole anesthetic agent speak for themselves. The "muscular spasm" and "twitchings" so frequently observed might well have been the heightening or augmentation effects of increased reflex activity as a manifestation of the central curare depression and subsequent "release phenomenon" as observed in our series.

S. M. Smith[24] recently reported his personal observations, in which he received, experimentally, 500 units of d-tubocurarine intravenously. He was totally paralyzed and was maintained on oxygen and artificial respiration (rebreathing bag). His sensorium was clear throughout the experiment and the conclusion was reached that curare is not an anesthetic and has no demonstrable action on the central nervous system. This conclusion, on the basis of one case, is too broad and too dogmatic. No one has ever claimed that curare is an anesthetic. It apparently does not act on the cortex. However, in order to be classed as a central depressant, it is not necessary for curare to anesthetize or narcotize the cortex. As suggested by Dr. Ernst P. Pick* curare primarily acts on the sub-cortex. The possibility must be considered that the antagonism of curare on

*Personal communication, unpublished

pasticity may be explained by its depressant action n the motor centers (mostly extra-pyramidal) of ne brain stem.

The foregoing observations of the effects of urare, (1) a sedative–like clouding of the sen- orium; (2) early augmentation effect; and (3) ite, protracted, relaxation effect, suggest a theo- etical mechanism of a direct action of curare on ne central nervous system, most probably a central epression, maximally on the sub-cortex. The early ugmentation effect suggests that curare might first epress the motor inhibitors, allowing the lower enters to become overactive (release phenomenon). eing phylogenetically older and thereby more esistant, the lower centers demonstrated their own epression later in the time phase of curare action y the protracted relaxation effect on clinical pasticity.

ONCLUSIONS

1. A group of 19 patients receiving prostigmine lone; 18 curare alone; and 14 prostigmine and curare n combination; were observed carefully for neuro- gical changes.

2. Eight of 19 patients receiving 1 mg. of prostig- nine revealed an early augmentation effect (increase f neuro-muscular activity as measured by spas- city, reflexes, and clonus); 1 an early diminution ffect, and 5 a protracted relaxation effect (anti- pastic).

3. Anti-spastic effects were observed in 5 patients fter injection of 1 mg. of prostigmine, in one case sting as long as 63 hours.

4. A sedative effect was observed in 16 out of 19 atients receiving curare alone in small doses (up to mg. per kilogram).

5. 9 out of 18 patients receiving curare alone owed an augmentation of neuromuscular activity.

6. Therapeutic relaxation was noted with curare lone in one case of hematomyelia, one of dystonia usculorum deformans, one of Friedreich's ataxia, wo of multiple sclerosis.

7. 10 out of 14 patients receiving the combination f curare and prostigmine demonstrated an augmen- tation of neuro-muscular activity, and 5 of this roup showed the protracted relaxation effect.

8. Although prostigmine and curare antagonize ach other peripherally, an apparent synergy of ese drugs on the central nervous system was noted n 5 patients out of 14.

9. The foregoing observations offer clinical support to the laboratory evidence that in addition to its peripheral paralytic action, curare has an independent action on the central nervous system, probably a depressant action, maximally on the subcortex.

REFERENCES

1. Bennett, A. E.: Curare in Convulsive Shock Therapy, The Trained Nurse and Hospital Review, March, 1940.

2. Bulbring, E., and Burn, J. H.: Acetylcholine Transmission, in the Spinal Cord, J. Phys., vol. 100, p. 337, 1941.

3. Burman, Michael, S.: Clinical Experiences with some Curare Preparations and Curare Substitutes. J. Pharm. and Exp. Therap., vol. 69, pp. 143-148, 1940.

4. Burman, Michael, S.: Therapeutic Use of Curare for Spastic and Dystonic States. Arch. Neurol. and Psych., vol. 41, pp. 307-325, 1939.

5. Burman, Michael, S.: Curare Therapy for Release of Muscle Spasm and Rigidity in Dystonia Musculorum Deformans, J. Bone and Joint Surgery, vol. 20, pp. 754-756, 1938.

6. Cullen, S. C.: Clinical and Laboratory Observations on Use of Curare During Inhalation Anesthesia. Anesthesiology 5:166-173, March 1944.

7. Denhoff, B., and Bradley, C.: Curare Treatment in Spastic Children, N. E. J. of Med., vol. 226, pp. 411-416, March 12, 1942.

8. V. Euler, U. S., and Wahlund, H.: On Central Action of Curare, Acta Physiol. Scandinav., 2:327, September, 1941.

9. Feitelberg, S., and Pick, E. P.: Action of Curare on the Brain of the Frog, Proceedings of Soc. for Exp. Biol. and Med., vol. 49, pp. 654-656, 1942.

10. Kabat, H., and Knapp, M. E.: Use of Prostigmine in Treatment of Poliomyelitis, J.A.M.A., vol. 122, p. 969, 1943.

11. Kabat, H., and Knapp, M. E.: Mechanism of Muscle Spasm in Poliomyelitis. J. Pediat. 24:123-137, vol. 24, Feb. 1944.

12. Kabat, Herman: Studies on Neuro-Muscular Dysfunction, Pub. Health Reports, vol. 59, p. 1635, Dec. 22, 1944.

13. Kabat, Herman: Neostigmine Therapy of Neuro-Muscular Dysfunction, M. Ann. District of Col., vol. 14, p. 248, June 1945.

14. Kabat, Herman: Neostigmine and Neuro-muscular Dysfunction. (Editorial) J.A.M.A. 128:812-813, July 14, 1945.

15. Kremer, M.: Intrathecal Injection of Prostigmine, Acetylcholine, and Eserine on the C.N.S. in Man. Quart, J. Exp. Phys., vol. 31, pp. 337-357, July 1942.

16. Kuffler, S. W.: Specific Excitation of the End-Plate Region in Normal and Denervated Muscle, Neuro J. Physiol. vol. 6:99, 43.

17. Luco, J. U., and Mesa, J.: Action of Curare on the Autonomic Neuro-Effector System, Ciencia, vol. 2, p. 298, Sept. 1941.

18. McIntyre, A. R., Dunn, A. L., and Tullar, P. E.: The Effect of d-tubocurarine on the Electrical Activity of Dog's Brains, Federation Proceedings, Part II, vol. 5, No. 1, Feb. 1946.

19. Merliss, J. K., and Lawson, H.: Effect of Eserine on Spinal Reflexes in Dog. J. Neurophysiol. 2:566-572, Nov. 1939.

20. Pick, Ernst P., and Unna, Kleus: Effect of Curare and Curare-like Substances on the Central Nervous System, J. of Pharm. and Exp. Ther., vol. 83, No. 1, Jan. 1945.

21. Riker, W. F., Wescoe, W., Clark, Cattell, McKeen, and Shorr, Ephraim: The Mechanism of Action of Prostigmine. Federation Proceedings, Part II, vol. 5, No. 1, Feb. 1946.

22. Schweitzer, A., Stedman, E., and Wright, S.: Central Action of Anti-cholinesterases, J. Physiol., vol. 96, pp. 302-336, 1939.

23. Schweitzer, A., and Wright, S.: Action of Eserine and Related Compounds of Acetylcholine on the Central Nervous System, J. Physiol. vol. 89, pp. 165-197, 1937.

24. Smith, S. M., et al: The Lack of Cerebral Effects of d-Tubocurarine, Anesthesiology, vol. 8. No, 1, Jan. 1947.

25. West, R.: Pharmacological Study of Derivatives of Two Specimens of Tubo-curare, and Examination of Four Members of Genus Strychnas and One Rubiaceous Plant associated with Curares of British Guiana. Arch. Internat. D Pharmacodyn. et de Therap. 56:81-116, June 15, 1937.

26. West, R.: Curare Pharmacology, Proc. Roy. Soc. Med vol. 28, pp. 565-578, 1935.

27. Whitacre, R. J., and Fisher, A. J.: Clinical Observation on the Use of Curare in Anesthesia, Anesthesiology, vol. March 1935.

CLINICAL PATHOLOGICAL CONFERENCE

PANCREATIC MALIGNANCY: PANCREATICO-DUODENECTOMY

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Chairman: A 63-year old, European-born graduate nurse, a widow, entered the hospital on June 4, 1946. She had, seven months prior to entry, first noticed some epigastric distress. This, she described, as being more a pressure than a pain. Simultaneously she developed anorexia and sustained a weight loss which, up to the time of admission, amounted to about 30 pounds. With these symptoms there was nausea and vomiting and there was constipation for the first time in her life. There was no melena. The stools varied in consistency with the cathartic used, but there were no large foamy or foul stools. The patient noticed that for a number of weeks prior to entry the epigastric discomfort had been brought on by exercise and was relieved by rest. In addition, she complained of a sensation of girdling pressure about the waist just below the costal margin. There had been some discomfort in the hips and in the right thigh. She had, therefore, taken aspirin and sodium bicarbonate for what she believed to be arthritis. No medication had been used for the epigastric complaint. Prior to the patient's admission a series of x-rays had been made in another city. These were reported as negative for gastro-intestinal or biliary tract pathology. Some arthritic change ha been noted in the spine. A week prior to entry th patient had had a gastro-intestinal series and a bariu enema in the outpatient department of this hospita

The only important matters in her systemic re view were that she had had hypertension for a lon time. Eight years previously she had had pneumonia Following this there had been a dry hacking cough which had persisted up until the onset of the presen illness, but had not been present during the pas seven months. She had reached her menopause sev eral years previously. The only other matter men tioned in her past history was an amputation of th cervix twelve years before.

Physical examination revealed a well developed but thin female who looked her age. She was in n apparent distress. Her blood pressure was 180/10 The pupils were normal in size and shape and reacte normally. The fundi were negative. There was n icterus of the sclerae. The nose, ears and mouth wer negative. The thyroid appeared normal and ther was no venous distention in the neck. The descrip tion of the heart was entirely normal. The lung were clear throughout. The back showed norma curvatures. There was no costovertebral angle ten derness and no sacral edema. The abdomen was fla and soft. The liver was felt 4 cm. below the costa margin. It was round, smooth and non-tender. I the mid-line there was a smooth, firm, rounde

ender mass extending almost to the umbilicus. The nass was felt to pulsate with the patient reclining. The extremities showed Heberden's nodes. The pulsations in the lower extremities were good. The eflexes were hyperactive. No sensory changes were noted and the neurological examination was negative. The patient's temperature was normal and remained so until after surgery.

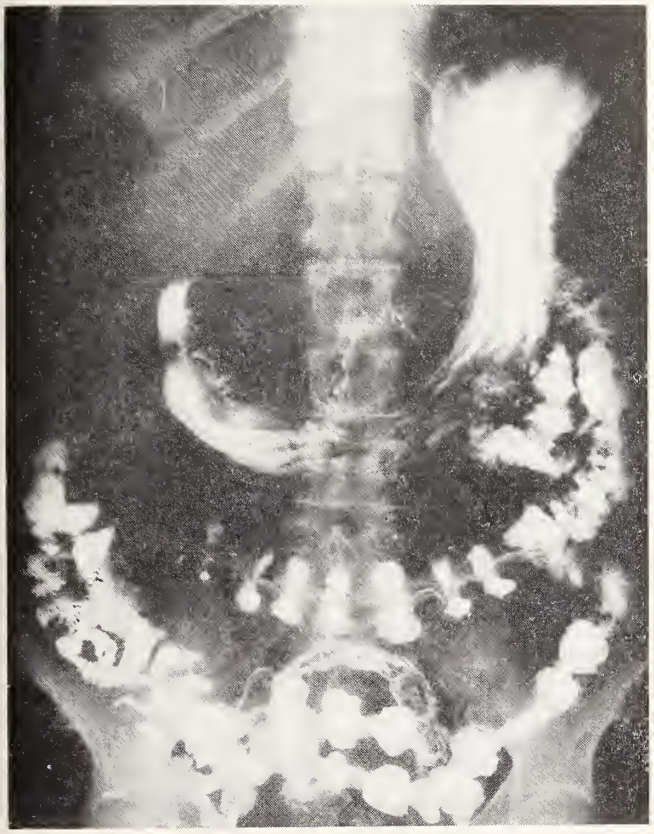


FIGURE 1

Laboratory studies revealed that the hemoglobin was between 70 and 75 per cent. The red cell count was 3.9 millions, the white count 6950 with 62 per cent of polymorphonuclears, 2 per cent being non segmented. The total serum protein was 5.65 grams per 100 cc. Sodium chloride was 610 mg. per 100 cc. in the plasma. The stools were negative by the guaiac test. Microscopic examination of the stools revealed that there was no undigested meat and rare fat globules. A few days after admission and following several blood transfusions the hemoglobin was 87 per cent and the red count 4,780,000. The white count became 19,450 with 82 per cent of polymorphonuclears and 19 per cent non segmented. Wassermann and Kahn were negative.

In addition to the blood transfusions the patient received amino-acids, a considerable amount of saline and glucose. In addition to this a number of x-ray studies were done. The x-rays are presented for your inspection. Dr. Lowman, will you please describe them and, in addition, I should be very glad to have your clinical impressions.

Dr. Robert M. Lowman: I should like to divide my discussion into two parts. First, I shall present the films and give you the roentgen findings. Second, I should like to consider the differential diagnostic aspects. As has been noted previously, the patient was first seen in the outpatient division. Film studies that had been completed in New York were reviewed at this time and it was considered that a mass lesion, possibly a pancreatic cyst of the gastrohepatic type, was present. At this time there was rounding along the lesser curvature of the stomach and displacement of this viscus into the left half of the abdomen. The roentgen studies which were completed here demonstrated, as you see, a displacement of the lesser curvature of the barium-filled stomach (Fig. 1). The sharply defined gastric wall showed distinct peristaltic activity and intact mucosal pattern. Easy and adequate manipulation of the gastric wall under roentgenoscopic control



FIGURE 2

indicates an extrinsic or extragastric lesion. The inverted "Figure 3" sign of Frostberg which is due to encroachment upon the duodenal shadow by perivaterial enlargement of the pancreas was not present. No widening or deformity of the duodenal loop can be demonstrated. There is only noted some deformity of the superior margin of the first portion of the duodenum. In the lateral view studies there is a constant deformity upon the posterior gastric wall (Fig. 2). This extrinsic pressure upon the posterior gastric wall was seen in both lateral views. The technique employed was similar to that suggested by Engel and Lysholm.[1] In this study, however, barium was used in the stomach instead of effervescing powder with vichy in order to more graphically demonstrate the defect pressing upon the posterior gastric wall and producing slight forward displacement of the stomach. In addition, the roentgen studies do not show esophageal or gastric varices. In the intravenous pyelograms there was no evidence of renal torsion. The kidney masses were normal in size, shape and position.

Now as to the second part of my discussion—the differential diagnosis. The roentgen findings conform to the clinical palpation of the abdomen which reveals a smooth, rounded, firm, mid-line mass. A rapidly growing tumor in the epigastrium strongly suggests pancreatic cyst, but this must be differentiated from an adrenal cyst, hepatic or omental cyst, hydronephrotic or cystic kidney, retroperitoneal tumors, tumors of the posterior gastric wall, aneurysm, splenic tumors and perhaps some other lesions. The appearance of the defect is such that it could not be produced by a mass arising from the anterior inferior aspect of the liver. The displacement of the stomach is such that it would be almost impossible for a hydroptic gallbladder to produce such a deformity. Tumors of the pancreas should be included in a discussion of retroperitoneal matters. It may not be possible to satisfactorily distinguish between a carcinoma of the pancreas and a retroperitoneal sarcoma. The primary retroperitoneal tumors arise in close proximity to the ureters and kidneys. For this reason urographic studies are important in these cases. If this tumor mass arises from remnants of the embryonal urogenital apparatus and is large enough to displace the stomach, it should in turn produce some degree of renal torsion. This is not present in this case. Moreover, in evaluating approximately 72 cases of retroperitoneal tumors of the pancreas or of pancreatic tumors, there was displacement of the kidnyes, ureters, or both, in only 4 of the cases. Th in spite of the fact that all of these tumors wer large enough to be palpable. This is in marked cor trast to the displacement of the kidneys or urete in over 72 per cent of the general group of retr peritoneal tumors.[2]

We have demonstrated an extrinsic extragastri mass producing a deformity of the posterior stomac wall and displacing the stomach anteriorly and t the left of the mid-line. We believe that the ma arises from the posterior abdominal wall in th region of the body of the pancreas. The ease wit which the duodenum and the stomach can be com pressed and displaced by pancreatic tumors account for the nausea and vomiting suggestive of intestina obstruction. It is not uncommon for the examinatio of the patient without jaundice in the early stage to demonstrate nothing abnormal in the gastro intestinal barium studies. Cases are reported i which, because of the lack of positive findings, a erroneous diagnosis of gastric neuroses or arthriti of the spine was made.

Dr. Samuel A. Jaffe: There are several other pos sibilities that should be called to attention. There i undoubtedly a large mass in the mid-line. One can not be certain that it is not in the biliary or gastro intestinal system. Neither can one be certain that i is not intrinsic, although it seems to be extrinsic It may be in the large bowel or it may be a mesen teric cyst, an aneurysm or any malignancy of th retroperitoneal region. One must also remember tha it might be inflammatory rather than malignant. Th pulsation described in the tumor is probably due t the fact that it rests on the abdominal aorta rathe than that it is an aneurysm. If it were merely a infectious or inflammatory mass there should b more in the way of symptoms and signs indicating this. The patient is not sick enough for a hydatic cyst. It could be a hepatoma in the lowermost por tion of the liver. I mention all of these possibilitie because Dr. Levy in his protocols in the past ha been, in many instances, extremely deceptive.

Dr. Robert H. Jordan: I am also very much in clined to go along with Dr. Lowman's diagnosis There is no evidence of previous liver disease such as cirrhosis which, if it were present, of course would be an excellent basis for a diagnosis of hepa toma. Jaundice is very variable in hepatoma and often appears very late in the disease. While it i difficult to reconcile the x-ray findings with a hepatoma, an abnormally-formed or situated liver

with a hepatoma could produce them. I believe that this is a case of malignancy. It is most likely retroperitoneal.

A House Officer: Would the fact that this woman was not jaundiced militate very strongly against the diagnosis of a pancreatic tumor? Wouldn't it also be true that the presence of pain sufficient to make a diagnosis of arthritis be against such a diagnosis? I have in mind the fact that tumors of the pancreas, particularly carcinomata, are usually described as accompanied by painless increasing jaundice.

Chairman: I have had occasion at these conferences during the past fifteen years or so to answer these particular questions rather frequently. In connection with the question of pain, practically all of the authors, even the old authors, refer to pain. As I recall it, in the edition of Osler's Textbook which I studied as a student, paroxysmal pain was referred to and was described as rather frequent. Opie,[3] many years ago, in writing concerning the symptoms of carcinoma of the pancreas, stated that pain was one of the earliest symptoms and is almost constantly present. I have had occasion in preparing protocols in the past to go over the figures which have been derived from the Mayo Clinic,[4] the Lahey Clinic,[5] and from other authors,[6] and have found that in at least half of the cases there is complaint of abdominal pain. Pain in the back is often present and independent of any other pain. In a very high percentage of cases where both jaundice and pain are present the pain makes its appearance first, the jaundice coming on at a later time. In connection with the question of jaundice itself where the pancreas is involved, one, of course, thinks of it especially when the head of the organ is the site of the tumor. In the edition of Gray's Anatomy which I studied as a student of medicine the common bile duct was described descending along the right border of the lesser omentum behind the first portion of the duodenum in front of the portal vein and to the right of the hepatic artery. It then passed between the head of the pancreas and the descending portion of the duodenum and ran a short distance along the right side of the terminal part of the pancreatic duct. It joined with the duct of the pancreas in most cases (about 90 per cent), the fusion of the two ducts forming, at their termination, the ampulla of Vater. In the latest edition of Gray's Anatomy which I have had occasion to consult in connection with this topic, the common bile duct is described in about the same way. It mentions a groove near the right border of the posterior surface of the head of the pancreas. In this last-named work and in some older English editions of Gray's Anatomy there is mentioned that the common duct occasionally is entirely embedded in the pancreas. In contrast to this, Opie's very excellent work[3] refers to the fact that in 25 cases out of 40 dissections the common bile duct was completely surrounded for a varying distance by pancreatic tissue. In Bockus' work[7] it is stated that the common duct is almost completely embedded in the pancreas in about 75 per cent of individuals. Many clinicians have come to regard this embedded relationship as the normal. It will, however, be realized that whereas jaundice due to compression of the common bile duct by tumor of the head of the pancreas is present in a very large percentage of cases, it is not necessarily present and there are a certain number of instances where the duct lies entirely exterior to the pancreatic substance. It is conceivable that some of these cases may escape without jaundice. As a matter of fact,, they do. Berk[6] has pointed out that 68 per cent of patients with pancreatic carcinoma have jaundice. It is, of course, less common when the body and the tail are involved. Nevertheless, about 1 out of every 5 tumors of the head of the pancreas do not have jaundice at any time. In connection with the whole subject of pain and jaundice it should be pointed out that about half of the cases of stone in the common duct do not have colic (McGavack).[8] Dr. Lear, would you be kind enough to tell us what type of operation you believe was performed in this case.

Dr. Maxwell Lear: The x-ray demonstration made by Dr. Lowman is so convincing that I have very little doubt about the preoperative diagnosis. I believe that the surgeon explored this patient with the thought of doing an operation involving the pancreas. If a tumor of this organ was found, and that seems most likely, he might very well have attempted or succeeded in removing the entire pancreas. Of late years this operation has been mentioned in the surgical literature. Such men as Brunschwig[9,10] and Whipple[11] have been most prominent in this connection. There have been a certain number of survivors of such operations. How many lived for any length of time postoperatively I am unprepared to say at this time. My impression, however, is that the figure is a very small one.

Chairman: Dr. Anthony J. Mendillo performed this operation. Unfortunately, he is not present today. I shall, therefore, give you a brief resume of

what was done. The preoperative diagnosis was retroperitoneal tumor. The postoperative diagnosis was advanced carcinoma of the head of the pancreas with retroperitoneal metastases. Under a spinal anesthetic supplemented by an inhalation anesthetic a mid-line incision was made in the epigastrium. A large carcinoma of the pancreas was found. The operation consisted of a pancreatoduodenectomy. The common duct was anastomosed into the proximal jejunum. After a gastrojejunostomy was done the proximal end of the jejunum was closed. A drain was placed in the abdomen and brought out through the lower angle of the wound. The postoperative condition was fair.

During and after operation 1000 cc. of citrated blood were given. Three days later the red count was down to 3.9 millions, the white count 13,700. The percentage of polymorphonuclears was 80, 13 of these being non segmented. The patient became jaundiced. Six days postoperatively the icterus index was 51. The van den Bergh was direct. Bilirubin was 6.8 mgs. Bile was present in the feces. A slight trace of amylase was found in the drainage from the abdominal sinus. Bile was also present in this. The abdominal fluid was amber-colored and turbid. Sections of it showed a mass of polymorphonuclear leukocytes. On another occasion the specific gravity of the abdominal fluid was 1.014 and it was negative for bile. There were 6 parts of albumin per 1000. Further transfusions were given. The patient was supported with oxygen, glucose intravenously and parenteral vitamin therapy. Wangensteen suction was used. Vitamin K was administered. Intravenous amino-acids were also used. The patient was given morphine as well as demerol. For the most part she was uncomfortable. At other times she was drowsy. She complained of tightness and pain in her upper abdomen. A rectal tube was used for distention. Eight days after operation the patient was noted as being bright and cheerful. She washed and fed herself. Later on she was up in a chair for a half hour and actually walked to the bathroom. Shortly thereafter she complained of severe pain and pressure in the right side of her abdomen and that night her appetite was poor. There was difficulty in breathing. There was frequent vomiting. Following this there was also very profuse drainage from the wound. This saturated the bed linen frequently. For a number of days the patient was taken out of doors in a wheelchair and exposed to the sunlight. Later on, when an attempt was made to take her out of bed, it was noticed that she seemed weak and bewildered. The remainder of her career was replete with medications, enemas, frequent vomiting and many complaints. At the very end her respirations were noisy and labored. Finally the pulse became imperceptible. She died on July 12, 1946 just one month postoperatively. Dr. Bartlett, will you please give the pathological findings of the specimen removed at operation and will you also give the postmortem findings.

Dr. Charles J. Bartlett: The specimen received from the operation consisted of a piece of intestine about twelve inches long already opened with an indurated irregular lump of what was presumed to be pancreatic tissue attached at about the region of the ampulla of Vater. This, on cross-section, was about 4 cm. thick, yellowish-gray in color, hard and finely granular, grossly resembling a malignancy. A second lump of similar tissue showed a rim of pancreatic substance at one end, but was predominantly a new growth. Frozen section diagnosis was adenocarcinoma. The microscopic examinations of the permanent sections showed an adenocarcinoma. This included the pancreas and the muscle coat of the intestine. There was much lymphoid tissue in the intestinal mucosa. The tumor was apparently primary in the pancreas.

The postmortem examination was performed by Drs. Kooiker and Hayes. I examined the organs and also the microscopic sections.

The autopsy was that of a 63-year old female. The body length was 58 inches. The weight was 102 pounds. There was considerable emaciation. The skin and sclerae were slightly icteric. The abdomen was moderately distended. There were some small decubiti over the left greater trochanter. The peritoneal cavity contained about 2500 cc. of cloudy yellow fluid. The heart weighed 300 grams and grossly showed no abnormalities other than thickening and sclerosis of the mitral valve. Both coronary arteries were patent throughout their entirety with only minimal arteriosclerotic changes being noted. Each lung weighed 400 grams. Nothing was noted in the way of occlusion of the major bronchi or major pulmonary vascular system on either side. There was consolidation of the right lower lobe and purulent exudate was found on scraping cut sections. Inspection of the peritoneal cavity revealed extensive adhesions throughout the upper abdomen. Recent anastomosis between the stomach and jejunum was present. A small localized collection of

purulent exudate was found in the transverse mesocolon at the site of the small bowel stoma. The common duct had been anastomosed to the most proximal portion of the jejunum. A fistulous tract was present from this anastomosis leading posteriorly into the lesser peritoneal cavity which contained about 60 cc. of bile-stained purulent exudate. The remainder of the small bowel appeared normal. One loop of ileum was adherent to the fundus of the uterus. There was a small collection of purulent material in the cul-de-sac. Another small localized abscess involved the sigmoid. The colon was dilated throughout its entirety and contained a large quantity of soft light-brown fecal material. The duodenum and pancreas had been removed and a small retroperitoneal collection of serosanguineous fluid was found in this area. No remnants of pancreas could be found. However, a large tumor mass about 6 x 8 x 5 cm. was found involving the root of the mesentery. The superior mesenteric and right colic arteries passed through this mass. The liver was smooth, normal in color and weighed 1100 grams. There were dilated biliary radicles. Only one area was suspicious in gross of metastatic neoplasm. The spleen was small and firm and weighed 120 grams. Serial sections of the pulp were fibrotic and the malpighian bodies were very prominent. Both kidneys appeared normal. The uterus was small. It weighed 120 grams and contained many small leiomyomata. Subserous and submucous nodules were present. Both ovaries were atrophic. The left one was involved in a localized collection of purulent exudate. The ureters and bladder were inspected and no evidence of obstruction or infarction was found. Examination of the abdominal aorta and internal iliac vessels showed no emboli and only minimal arteriosclerotic changes were found. The gross anatomical diagnosis was basilar pneumonitis, postoperative pancreaticoduodenectomy and choledochojejunumostomy with fistulous opening into the lesser peritoneal cavity, questionable metastases to the liver (from removed pancreas), localized peritonitis.

Microscopic examination revealed the following: The lungs showed patchy pneumonia. Sections of the tumor mass described in gross showed an adenomatous growth in fibrous tissue. Its primary site was not evident from the autopsy itself. The liver did not show any tumor growth. The kidneys showed some parenchymatous degeneration.

Chairman: In this day of cancer consciousness it is interesting to observe that a procedure that was started as far back as 1888 and which was pursued by Halsted ten years later, was described in 1905 by Moynihan as being accompanied by such mechanical difficulties as to make the operation well nigh impossible. Moynihan felt that if boldness and good fortune were the operator's gifts the result to the patient hardly justified the means. A group of Baltimore men (Trimble, Parsons and Sherman)[12] have summarized the recent knowledge concerning this matter. This and their own experience indicate that the problem is by no means as hopeless as it seemed to be. In a case reported by this group, they had an opportunity to do a frozen section prior to radical completion of the operation. When this showed an adenocarcinoma they proceeded to resect the growth with its duodenal, choledochal and pancreatic connections. This patient was alive nearly one year later and seemed to be in excellent health.

In closing this exercise I should like to point out one matter. We have in the past presented at our conference here a number of cases where the surgeon, on palpation, believed that he was encountering a carcinoma of the head of the pancreas. An anastomosis between the gallbladder and the stomach or of some other portion of the neighboring gastro-intestinal canal was performed. Some of these cases surprisingly have lived for a very long time. In some instances we have had opportunity to examine the pancreas after death. A purely inflammatory mass was discovered in several of these cases that I have in mind—a so-called Riedel's tumor. In such cases the overcoming of the jaundice by anastomosis between the gallbladder and the gastro-intestinal tract was a life-saving procedure and, of course, radical surgery was unnecessary. For these reasons, if it is at all possible to get good frozen sections prior to radical resection, it seems very desirable before the extremely formidable surgery which is necessary in these cases is undertaken.

REFERENCES

1. Engel, A., and Lysholm, E.: New Roentgenological Method of Pancreas Examination and its Practical Results. Acta Radiol., 1934, 15:635.

2. Schulte, T. L., and Emmett, J. L.: Urolography in the Differential Diagnosis of Retroperitoneal Tumors. J. of Urology, 1939, 42:215-219.

3. Opie, E. L.: Disease of the Pancreas, 2nd ed., 1910, Philadelphia, J. B. Lippincott Co.

4. Eusterman, G. B., and Wilbur, D. L.: Primary Malignant Neoplasms of Pancreas; Clinical Study of 88 Verified Cases Without Jaundice. South, M. J., 1933, 26:875.

5. Lahey, F. H., and MacKinnon, D. C.: Carcinoma of Pancreas. S. Clinics of North America, 1938., 18:695.

6. Berk, J. E.: Diagnosis of Carcinoma of Pancreas. Arch. Int. Med., 1941, 68:525.

7. Bockus, H. L.: Gastro-Enterology. 1946, Philadelphia, W. B. Saunders Co., Vol. III, 427.

8. McGavack, T. H.: Diseases of the Pancreas. In Practice of Medicine, Tice F., Vol. VII, pg. 50a.

9. Brunschwig, A.: Surg. Gynec. and Obst., 1937, 65:681-684.

10. Brunschwig, A.: Surgery of Pancreatic Tumors, 1942, St. Louis, C. V. Mosby Co.

11. Whipple, A. O., Parson, W. B., and Mullins, C. R.: Ann. Surg., 1935, 102:763. Whipple, A. O.: Am. J. Surg. 1938, 40:260. Whipple, A. O.: N. England J. M. 1942, 226: 515.

12. Trimble, R., Parsons, J. W., and Sherman, C. P.: A One Stage Operation for the Cure of Carcinoma of the Ampulla of Vater and the Head of the Pancreas. Surg. Gynec. and Obst. 1941, 73:711.

ANEMIA IN HYPOTHYROIDISM

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That anemia may result from hyperthyroidism has been known for years, but it is probable that the factor of hypothyroidism is often overlooked in determining the etiology of obscure anemias or those anemias failing to respond to iron and liver therapy. One reason for this is the fact that diminished metabolism may be present without the distinctive clinical features of myxedema.

Baldridge and Greene[1] stated that the clinical manifestations of myxedema are enough like those of pernicious anemia to account for the fact that myxedema is more often mistaken for pernicious anemia than for any other disease. They treated five cases with liver extract and obtained no response. The case which will be presented at the end of this paper was, in fact, treated as a case of pernicious anemia. In uncomplicated pernicious anemia, however, the basal metabolic rate is elevated and the cholesterol reduced.

Jaffé[2] emphasized the importance of hypothyroidism in the pathogenesis of obscure anemia. He cited a case of severe anemia of an aplastic type in an elderly woman which offered great diagnostic difficulties. At autopsy the thyroid gland was completely replaced by dense scar tissue, and there were signs of depressed activity of the bone marrow. This patient did not show symptoms of myxedema. Three years before death the basal metabolic rate was minus 32 per cent.

Jaffé[2] stated that since patients like this do not show signs of myxedema, the grave disturbance of the thyroid gland is likely to be overlooked unless the basal metabolic rate is determined. The lack of response to liver and iron medication then leads to the conclusion that one is dealing with an obscure primary anemia which cannot be classified. Study of the structure of the blood cells and the hemoglobin metabolism does not help much in giving any definite information as to the nature of the anemia, and in the terminal stage a blood picture may develop which is suggestive of aplastic anemia. Such an anemia will respond only to thyroid medication.

The anemia in hypothyroidism may be either hypochromic or hyperchromic in type, but is usually the latter. Bomford[3] has divided the anemias into three types: the simple hyperchromic, the hypochromic, and the Addisonian hyperchromic. His classification is of value in the diagnosis and treatment of hypothyroid anemias and will be presented in some detail.

The first type, simple hyperchromic, is the true, uncomplicated anemia of myxedema. The color index is normal or a little above one. There is macrocytosis but no poikilocytosis and no excessive anisocytosis. The red cell count is rarely lower than 3,500,000 and the mean corpuscular volume may be 95 to 120 cubic microns, while the mean corpuscular hemoglobin concentration is normal. The reticulocyte count may be normal or a little above normal. The serum bilirubin is normal, and when the skin is yellow the color is due to carotinemia. The fragil-

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ity of the red blood cells in saline is slightly increased. There may be free hydrochloric acid or there may be complete achlorhydria. The anemia disappears very slowly on prolonged treatment with thyroid alone, taking from three to nine months. There is no reticulocyte response. Treatment with liver and iron has no effect on the anemia.

The results of other workers tend to confirm Bomford's classification of the simple hyperchromic type as the true anemia of myxedema. Stern and Altschule[4] made hematological studies on cardiac patients following total removal of the normal thyroid gland for the alleviation of congestive heart failure and angina pectoris. An anemia developed which was macrocytic and hyperchromic, being characterized by an increased color index, mean corpuscular volume, and mean cell diameter. The appearance of the anemia following operation coincided with a drop in the basal metabolic rate. The anemia improved only when the basal metabolic rate was increased by the administration of thyroid. At the level of metabolism of about minus 25 per cent usually maintained in patients after total thyroidectomy the blood changes were not great enough to give rise to symptoms of anemia.

The results of Kunde et al[5] also support Bomford's classification. They found that in experimental hypothyroidism in the rabbit the anemia was characterized by a color index greater than one, an increased red blood cell diameter, a normal hydrochloric acid contents of the gastric juice, and a bone marrow which did not simulate either grossly or microscopically the bone marrow of pernicious anemia. The cholesterol content of the blood was greater than normal.

Sharpe and Bisgard[6] also worked with rabbits which had had a complete thyroidectomy. They found a rapid development of a persistent macrocytic anemia. These same workers in another study[7] found that the daily administration of thyroid extract to adult, anemic, thyroidectomized rabbits caused a well marked reticulocyte response followed by a sharp and sustained rise in both red cells and hemoglobin. Intramuscular liver caused only a slight rise in red cells and hemoglobin. Iron had almost no effect.

Bomford's[3] second type of anemia is called the hypochromic. A case of this type is one of an iron deficiency anemia modified by the co-existence of myxedema. The administration of iron would convert the case into the simple hyperchromic type. Except in the matter of cell size, the blood picture closely resembles that of idiopathic iron deficiency anemia. There may or may not be macrocytosis. Some degree of poikilocytosis and anisocytosis are present. There may or may not be achlorhydria. The anemia usually responds rapidly to combined treatment with iron and thyroid.

The third type of anemia is called the Addisonian hyperchromic. A case of this type is one of true Addisonian pernicious anemia modified by the co-existence of myxedema. Treatment with liver alone would convert the case into the simple hyperchromic type. Other signs of pernicious anemia including subacute combined degeneration of the spinal cord may be present. The blood picture closely resembles that of uncomplicated pernicious anemia but the color index is often higher. The serum bilirubin is usually raised. Complete gastric achlorhydria is present. The anemia responds rapidly to combined therapy with thyroid and parenteral liver.

Paul et al[8] studied the effect of myxedema upon hemopoiesis in leukemia and related disorders. Erythropoiesis was depressed in polycythemia vera after a total thyroidectomy and development of myxedema. The anemia was macrocytic and hyperchromic in type. Leukopoiesis was unaffected.

Jones[9,10] studied human sternal bone marrow in myxedematous states. Sternal marrow aspirated from eighteen "normal" individuals contained an average of 6.2 per cent nucleated cells. Sternal marrow from seven individuals with hypothyroidism contained an average of 2.4 per cent nucleated cells, a little more than one-third of the normal average. Five cases of hypothyroidism treated with desiccated thyroid showed a marked rise in the percentage of nucleated cells in the sternal marrow.

Bomford[3] presented his theory as to the role of the thyroid gland in erythropoiesis. He believes that thyroxine is not a necessary factor for normal maturation of the red blood cell. The thyroid plays no direct part in erythropoiesis. The anemia in myxedema, unless complicated by iron or liver deficiency, is a physiological adaptation on the part of the blood system to a diminshed need of the tissues for oxygen. This adaptation is analogous to that which occurs in animals exposed to an increased oxygen tension of the inspired air. The effects of the thyroid on erythropoiesis are indirect results of changes in the rate of metabolism.

REPORT OF A CASE

The following case is still under treatment. It represents a true, uncomplicated anemia of myxedema which is responding very slowly to treatment, one of the characteristics of this type. After seven months of administration of thyroid extract there has been a rise in hemoglobin of 6 per cent or 0.9 grams per 100 cc. Macrocytosis is still present.

M. P., a 43-year-old white woman, was first referred to me in August 1947 for investigation and treatment of her anemia. The past history revealed an appendectomy and cholecystectomy 20 years ago. In 1939 symptoms appeared which probably marked the onset of hypothyroidism. At this time her menses became profuse. In 1941 she was admitted to the New Britain General Hospital for transfusions because of severe vaginal bleeding. Blood count at that time was R.B.C. 3.0 million and Hb. 53 per cent or 8.3 grams per 100 c.c. This was a hypochromic anemia, and the diagnosis was secondary anemia due to acute blood loss. Gastric analysis revealed free hydrochloric acid. A note was made that her anemia did not respond to iron therapy.

In 1942 she was again admitted to the hospital for studies which revealed a B.M.R. of minus 20 per cent, R.B.C. 4.0 million, Hb. 81 per cent or 12.6 grams per 100 c.c., reticulocyte count 0.5 per cent, and Kline exclusion test negative. She received some thyroid medication for about 3 months only, with apparently no marked rise in her metabolic rate.

From 1942 to June 1947 she received weekly injections of liver and an iron-liver preparation by mouth without any rise in her blood count. In August 1947 she had few symptoms relative to her anemia. Her menstrual periods were regular and moderately profuse, lasting 5 days.

Examination revealed a typical case of myxedema with all the classical symptoms and physical findings. The examination was otherwise essentially negative. The B.M.R. was minus 40 per cent. Gastric analysis revealed free hydrochloric acid. The blood picture revealed a macrocytic, hyperchromic anemia, details of which are given in Figure 1.

She was then started on thyroid extract beginning with ½ grain daily and increasing gradually over a period of 3 months to a maintenance dose of 3 grains daily. Her B.M.R. was then minus 7 per cent. Shortly after starting treatment she showed the classical responses to an increasing metabolic rate. Her menstrual periods became shorter and were no longer profuse. She was also given a therapeutic trial with oral doses of ferrous sulfate and folic acid for 3 months but these had no effect whatsoever on the anemia.

After 7 months of treatment with thyroid extract there has been a small but definite rise in the red blood cell count and the hemoglobin, details of which are given in Figure 2.



FIGURE 1

Before Treatment

B.M.R.—40 per cent
R.B.C. 3.2 million
Hb. 66 per cent or 10.3 grams
C.I. 1.07
Reticulocyte 0.8 per cent
Hematocrit (Wintrobe) 34 per cent
M.C.V. 106 cu. μ
M.C.H. 32 $\gamma\gamma$
M.C.H.C. 30 per cent



FIGURE 2*

After 7 Months of Treatment with Thyroid Extract

B.M.R.—7 per cent
R.B.C. 3.8 million
Hb. 72 per cent or 11.2 grams
C.I. 0.98
Reticulocyte 0.3 per cent
Hematocrit (Wintrobe) 40 per cent
M.C.V. 105 cu. μ
M.C.H. 29 $\gamma\gamma$
M.C.H.C. 28 per cent

COMMENT

In 1941 when this patient was hospitalized for severe vaginal bleeding she presented a picture of hypochromic anemia. At that time the anemia would be classified as Bomford's[3] second type—an iron deficiency anemia modified by the co-existence of hypothyroidism. The long continued administration of iron while the metabolic rate was falling converted the anemia into the true, simple hyperchromic anemia of hypothyroidism. The very slow rise in the red blood cell count and hemoglobin after a 7 months period of thyroid therapy is characteristic of this type of anemia. It is expected that this slow rise will continue and that the macrocytosis will gradually regress.

SUMMARY

Three types of anemia resulting from hypothyroidism are described. The first type, simple hyperchromic, is the true, uncomplicated anemia of hypothyroidism. The second type is the hypochromic, an iron deficiency anemia modified by the co-existence of hypothyroidism. The third type, the Addisonian hyperchromic, is one of true Addisonian pernicious anemia modified by the co-existence of hypothyroidism. The theory is presented that the thyroid gland plays no direct part in erythropoiesis, but that the effects of the thyroid gland on erythropoiesis are indirect results of changes in the rate of metabolism. A case is presented which is an example of both the first and second types of anemia resulting from hypothyroidism.

BIBLIOGRAPHY

1. Baldridge, C. W., and Greene, J. A.: Absence of Response of Anemia of Myxedema to Liver Extract, Proc. Soc. Exper. Biol. and Med. 31:1035, June, 1934.

2. Jaffé, R. H.: Severe Anemia of Aplastic Type Associated With Sclerosis of Thyroid Gland, Arch. Int. Med. 61:19, January, 1938.

3. Bomford, R.: Anaemia in Myxoedema, Quart. J. Med. 7 (N.S.): 495, October, 1938.

4. Stern, B., and Altschule, M. D.: Hematological Studies in Hypothyroidism Following Total Thyroidectomy, J. Clin. Investigation 15:633, November, 1936.

5. Kunde, M. M., Green, M. F., and Burns, G.: Blood Changes in Experimental Hypo-and Hyper-thyroidism (Rabbit), Am. J. Physiol. 99:469, January, 1932.

6. Sharpe, J. C., and Bisgard, J. D.: The Relation of the Thyroid Gland to Hematopoiesis, J. Lab. and Clin. Med. 21:347, January, 1936.

7. Idem: The Thyroid Gland and Hematopoiesis, ibid. 23:219, December, 1937.

8. Paul, J. T., Limarzi, L. R., and Seed, L.: The Effect of Myxedema Upon Hemopoiesis in Leukemia and Related Disorders, Am. J. M. Sc. 206:625, November, 1943.

9. Jones, R. M.: Human Sternal Marrow in Hyperthyroid and Myxedematous States, Proc. Soc. Exper. Biol. and Med. 41:55, May, 1939.

10. Idem: Human Sternal Bone Marrow in Hyperthyroid and Myxedematous States, Am. J. M. Sc. 200:211, August, 1940.

OPHTHALMOLOGISTS AND OPTOMETRISTS — A POSSIBLE SOLUTION TO A PROBLEM

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In an attempt to discredit the medical profession and to create a more favorable attitude toward the socialization of medicine, the long range political schemers have, through the courts in the mid-west area, brought before the public an unfortunate but true unsavory kick-back situation. The men named by the courts are only unfortunate symbols of the so-called criminals that *we*, as the majority of ophthalmologists who depend in part upon their living on the profit in the sale of glasses, represent.

In order to prevent a too hasty condemnation of peoples involved it is well to have a better understanding of the reasons why such an apparently disreputable situation exists. A better knowledge of ophthalmologists and optometrists as individual groups, their problems and their relationship to the medical practitioner and the public is essential. It is obvious there is a place in the medical economic set-up of the nation today for both groups but there is no place for the antagonism, the misunderstanding, the duplication of effort that exists. Placing each group in proper relationship can eliminate the need for the unsavory kick-back situation. This will benefit the profession and the general public.

In 1927, the American Medical Association passed a resolution outlawing or condemning optometry and set up the real social and economic pitfall into which the profession of ophthalmology has been drawn unwittingly. As on the surface this 1927 Resolution appears to be a step in the right direction, we will go further and divide eye and ear, nose and throat, and consider the situation strictly from the standpoint of the ophthalmologist.

To further understand this situation, we must analyze the average ophthalmologist's practice. It is, roughly speaking, divided into a large number of normal patients perhaps needing glasses and a small number of pathological patients needing medical or surgical care. For instance, Harman, analyzing the British National Eye Service 1934-38, quotes pathological conditions as representing 25 per cent of the total. Gradel gives pathological eye cases as 30 per cent of all cases seen in his office. DeRotth quotes pathological eye figures at 44 per cent and Downing quotes ocular defects of 60,000 selectees in 1945 as being only 14 per cent pathological. Glover and Brewer's figures on ocular defects in 1944 quote 2- per cent of eye defects as being pathological. In other words, it is reasonable to conclude that since there has been no satisfactory survey made in this particular phase of the work, only about 25 per cent of all eye cases referred to the ophthalmologist can be assumed to be pathological.

This will reduce by general acceptance the number of surgical cases to approximately 1-2 per cent of all cases seen. This gives an ophthalmologist a practice of about 75 per cent purely mechanical refractions. In other words, he spends only about 25 per cent of his time doing the things that he went to school for for six to eight years, starved through a year or two of general internship and three years of residency and for which he spent $25,000 to $30,000. Seventy-five per cent of his time he spends doing those procedures which he could have learned by going to a mechanical arts school for two years, yet most of his income comes from this source. Most men feel that doing refractions is very definitely an integral part of their work and is necessary, yet there are few who will voluntarily say that they enjoy doing them.

There will never be in this country enough ophthalmologists to do all the refractions the public requires. Therefore, the optometrist will always be needed. He is trained to fit glasses well but is not expected, trained, nor does he wish to undertake the responsibilities of medical or surgical eye care. The ophthalmologist, on the other hand, if he is really interested in his work, glories in the very work that the optometrist does not want. However, at the present time both groups must do refractions because of the economic set-up encouraged by the 1927 Resolution. This makes it unethical for the ophthalmologist to work with the optometrist.

Let us see how this situation works. The typical course of events is that 7 out of 10 eye men locate outside of population centers. Because of the 2 per

ent incidence of surgery the first few years of practice, they operate perhaps once or twice a year, nd by the end of their third or fourth year of practice they are scared to do any major surgery ecause they have "lost their touch." There just are ot enough cases there. Soon they are sending the omplicated cases out of town sacrificing the train-ng that they have had. At the same time, there are ptometrists selling glasses at a good profit and naking a better living than the eye men. The phthalmologist has to obtain a decent fee to live on professional basis and his refractions must furnish his fee as they comprise 75 per cent of his work. If e attempts to charge a reasonable price for this vork, he will find that, with the cost of the glasses, his represents to the patient a prohibitive situation naking the cost of the glasses and refraction fee nuch higher than the price of the optometrist, so nedical care becomes too costly. The patient goes o the optometrist because of the cheaper fee and he optometrist matches or doubles the ophthal-nologist's fee for the refraction because he obtains profit from the sale of the glasses.

To come somewhere near to a legitimate examin-ng fee and still stay in business, the ophthalmologist nust make part of his fee from the sale of the glasses. At this point, the question arises, "Would not it be nore honest to allow the ophthalmologist to charge full legitimate fee and reduce the price of the glasses so that the full cost would not be excessive o the patient?" Right you are. But you have for-gotten that the optometrist who does not have the opportunity to expect the same fee as the ophthal-nologist (some are getting more) is taking his fee n the profit of the glasses, and as two out of three nen examining eyes for glasses in the United States re optometrists, you can see who is going to raise he biggest objection if the price of glasses were educed. In the United States, we have, according to he figures given by The Society For The Preven-ion of Blindness, 18,000 optometrists against 1,800 ertified ophthalmologists and 4,400 eye, ear, nose nd throat men doing some eye work. The medical profession is out-numbered in this phase of the situa-ion and the wholesale opticians are reluctant to tab their best customers in the back, figuratively peaking.

In California, the retail opticians have had the ourage to make a progressive step in the right irection inasmuch as the medical profession has aken the first step and demanded that their own nen put the whole problem on an honest basis. In other words, they refuse to accept rebates and have demanded that the dispensing optician, on a retail basis, reduce the price of the glasses accordingly to the patient, which allows them to obtain a legitimate fee without rebate. The economics of selling glasses at a high profit has created all over the country a group of physicians who have been making or who are making a good living but who, by the low incidence of medical or surgical eye cases, have been denied the opportunity to develop a real career and are satisfied to drift into the easy way of getting by. They are actually simply competing with the optometrists on practically the same business basis. Both men are thus sending their complicated eye cases out of town or elsewhere for service and this plays into the hands of the men who have developed the surgical practices in the larger centers. They play the optometrists and ophthalmologists who do not prefer to operate—or cannot.

Although this situation is not exactly the same in every part of the country, the general situation is more or less true. In certain centers of population, where the level of medical care is higher due to close proximity of postgraduate educational opportunities and clinical practice, many individuals have developed their own medical and surgical skills to a level for which the patient has been glad to pay the extra fee involved. In other centers, the average medical men have been reluctant to accept rebate or profit from the glasses but the economic custom had been so established that there was no way to buck it. These men are now the unfortunate victims of the present legal action.

It is not my point to condemn any particular group for any activity they are involved in because I feel many are victims of circumstances beyond their control. However, we do need to take some action to correct this situation or otherwise we shall fall by the wayside.

The solution to the problem is simple, technically, and the Army and Navy have solved it. There is no duplication of effort. The ophthalmologist and optometrist work side by side. On the civilian side of the situation, the solution economically is difficult.

Speaking bluntly, the optometrist should stop practicing medicine and the ophthalmologist should stop practicing optometry. Let us work together for a change for the ultimate benefit of both groups. We know it is impossible to ever train enough physicians to do all the refractions. There are not enough interns or medical students interested in

entering the specialty. There is little glamour to refracting. Let the optometrist do the work in the office, side by side with the M.D., thus allowing the M.D. to be a doctor instead of a "goggle fitter." This will eliminate immediately the great need of so many ophthalmologists as 75 per cent or more of their time would be released from fitting glasses. The present and future ophthalmologist could then devote his time to some of the psychosomatic aspects of the field, he could really take the time to do the work that he is trained for, take better histories with a more thorough knowledge of his patients. The optometrist in the doctor's office, under his supervision, can do a good refraction for which he is trained and he can do it without the fear of possibly having "missed something" which he is not actually trained to pick up and yet today brings him the most criticism. The doctor needs the careful refraction of these eyes before analyzing them for the ultimate final diagnosis in each particular case and by so splitting this labor he can have sufficient time to devote to better medical care of the patient.

There are millions of pairs of glasses sold unnecessarily in this country because certainly the optometrist should not be expected to understand the full medical, surgical and psychosomatic aspects of the individual before him. The secret to the whole solution is in the cost of the glasses. The price of the glasses could be and should be adjusted so as to eliminate the economic battle-ground between these two professions and then the public will get the price benefit, the medical profession the work division and last, the optometrist will gain through this combination although at the present time he is most against such reorganization.

This reorganization, if at all possible, is going to take a great deal of time and effort and the overcoming of many economic odds. We as medical men must take the initiative or otherwise we will lose face with the public and the public will lose faith in us. We cannot allow the present situation to continue as it is. In our efforts, if we are completely united as eye men, 1,800 certified ophthalmologists and 4,400 eye, ear, nose and throat men, we are outnumbered 3 to 1 by the optometrists. So you can see what a job it will be to reorganize the whole set-up. Unless we make these steps intelligently, the whole situation will crash down around our heads in an economic morass to the disgrace of our own profession. The degree of profit-taking, rebates, and so on and so forth, varies all over the country. I am positive that the medical profession is anxious and willing to take every step in its power to correct this and give the public an honest break. In the state of Connecticut we, fortunately, have a rather clean bill of health along this line. This is largely due to the fact that M.D.'s have refused by and large to take rebates and the retail opticians and Guild opticians, etc. have more or less worked with them. Optometry in this state has raised itself to a higher level than it occupies in many other states and we do have optometrists working with doctors in their offices in various parts of this state. It is obvious there must be a reasonable return to the doctor for his investment and effort to go through medical school, internships, etc., and also there must be a reasonable return to the other groups for their service to the public. Sacrifices and adjustments must be made by all groups. Greater advances can be made by better understanding of the whole problem by the general medical profession as well as the general public. After all, many of the general public don't know the difference between optometry, ophthalmology and opticians.

Remove the economic battleground by adjusting glasses prices lower, let the optometrist work in the doctor's office or closely with him and let the ophthalmologist have time to develop surgical and medical eye practices. Thus we will attract good men into ophthalmology as they will do well medically as well as economically and the public will get better glases, better medical care and at a more reasonable cost.

REFERENCES

"Mr. N. Bishop Harman's Third Analysis;" The Optician, British Optical and Instrument Journal, Vol. XCII, No. 2380, November 6, 1936, p. 237.

A Statistical Analysis of Ophthalmic Patients by Harry S. Gradle; American Journal of Ophthalmology, Vol. 14, No. 2, February, 1931.

Statistical Analysis of 1,000 Consecutive New Eye Patients by Andrew DeRotth, M.D., Spokane, Washington; American Journal of Ophthalmology, Vol. 28, No. 12, December, 1945, pp. 1329-34.

Ocular Defects in Sixty Thousand Selectees by Capt. Arthur H. Downing, Medical Corps, Army of the United States; Archives of Ophthalmology, Vol. 33, No. 2, February 1945, pp. 137-143.

An Ophthalmologic Review of More Than Twenty Thousand Men at the Altoona Induction Center by L. P. Glover, M.D., and William R. Brewer, M.D., Altoona, Pa.; American Journal of Ophthalmology, Vol. 27, No. 4, Series 3, April, 1944, pp. 346-348.

SCREENING AS A VIEWPOINT IN MEDICAL PRACTICE

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THE DUTY of a physician is something more than just diagnosis and treatment. It includes a responsibility for the recognition of disease processes in their earliest stages. This obligation is implied by current teaching in medical schools and is often taken for granted by patients. Yet the economic factors in medical practice have often precluded the attainment of this goal. Physicians with established reputations in the treatment of progressive diseases are often impatient with the inadequate achievements of their colleagues, particularly those in basic community practice who must at small fees see many patients each day.

During his professional schooling the medical student is enjoined to examine each patient in great detail. Emphasis is placed upon the necessity for elucidating all the minutiae of the familial and past histories as well as recounting seriatim a long list of symptoms referable to the various organs of the body. Likewise the examination is elaborated to enormous length. This meticulousness is an essential part of pedagogy, but too often no effort is made to streamline this training for practical application. Most physicians therefore work out their own shortcuts. These frequently lead to overlooking all parts of the body except those suggested by the presenting symptoms. The history form suggested by Cabot and Adams[1] cannot possibly be concluded in less than 45 minutes and even then must be followed by a physical examination and laboratory procedures. Even in specialized internal medicine (where the fees are somewhat higher than in basic community practice) such an examination hardly pays the overhead, and the physician may be dependent for his profit upon more rapidly rendered services such as follow-up visits and injections.

Numerous short screening examinations have been devised by various agencies, and these are generally adequate for the specific purposes of their originators. Life insurance companies utilize standard forms which can be completed in less than 20 minutes and are adequate to detect in applicants a suspicion of any of the 13 disease groups which are leading causes of death in this country.* At the usual fee of $5 such an examination is profitable to the examiner, but it is not a suitable prototype for the examination needed by the private patient. Questions like, "Have you ever had a chest x-ray, sugar tolerance test, or electrocardiogram?", are useful in excluding applicants who themselves know that they are suffering from tuberculosis, diabetes, or coronary heart disease, but fail to detect these diseases in patients who suppose that they are in good health.

The military services also have standard examination forms. For military needs the greatest importance must be placed on objective findings. Military physicians know that the motivations which lead candidates to such examinations are so variable that the history is almost worthless. Many of the factors noted are measurements such as height, weight, visual acuity, auditory acuity, and response of the pulse or blood pressure to exercise—observations of importance in evaluating a man's fitness for specific military tasks but of little value as indices of progressive disease.

Since the insurance examination, the military examination and the elaborate examination outlined by the medical school all fall short of meeting the requirements of medical practice, it is pertinent for the physician to ask himself two questions:

1. Can a "screening" examination bring to light the early stages of progressive fatal or disabling diseases with sufficient frequency to warrant its routine use?

2. Can a "screening" examination be devised which is brief enough to be adopted under the existing form of medical practice?

*Heart disease, malignant disease, cerebro-vascular disease, nephritis, accidents, pneumonia, diseases associated with pregnancy and the neonatal period, diabetes, tuberculosis, nervous and mental diseases, appendicitis, gall bladder diseases, cirrhosis of the liver.

The information necessary to answer the first of these questions is difficult to obtain, and the author, even after considerable study of the statistical frequency of diseases, does not have a "pat" answer. There can be little doubt, however, that those who treat tuberculosis, carcinoma, and mental diseases are thoroughly convinced that periodic examinations are of paramount importance. So, too, are workers in the public health field who by fresh statistics are constantly reminded of the preventable toll of disability and death. Whatever conclusion one may reach with regard to the necessity for periodic examinations of asymptomatic persons, it is amply clear that every physician should in his routine work bear in mind the thirteen leading causes of death and attempt to recognize them in their earliest stages.

Considerable light is available as to the practicability of devising a satisfactory "screening" examination.[2] There are in all about 2,000 diseases. Of these, 186 account for 96 per cent of all the death and disability in the United States. The earliest stages of these 186 diseases can in most instances be recognized from 130 specific historical, physical, or laboratory abnormalities. These 130 individual abnormalities can be grouped in such a way that the physician has to bear in mind only forty-five items in examining his patient.

There are only seventeen key historical questions. These consist of general interrogations as to the functions of the various organ systems. Discharge of blood or pus from any of the bodily orifices is particularly important. Elaborate questions into the past or family history serve to amplify any positive finding but ordinarily contribute too little to be of importance in routine "screening." The "screening" questions should be built around familiar vernacular terms such as "lameness." "Lameness," if present, requires considerable elaboration, but if absent, excludes most of the arthritides, neuritides, and peripheral vascular disorders. By the use of a few well selected terms with broad meanings the functioning of the entire body can be covered in a few moments.

The technique of physical examination cannot be simplified a great deal, but such an examination (omitting measurements) can be performed in short order provided one has immediate access to the unclad patient. *Hence, the ability to perform a rapid physical examination depends upon the architecture of the office.* Multiple small examining rooms equipped with desks make it possible to take the history and examine the patient without wasting time in ushering him from one room to another or allowing him to tie up critical space while he disrobes. Pediatricians have mastered this lesson and in general have learned to examine the entire patient with a minimum of discomfiture.

The laboratory procedures necessary for a "screening" examination constitute more of a problem, and although they can be delegated, still add materially to the overhead and tend to render the examination economically unprofitable. They include urinalysis, hemoglobin determination, sedimentation rate, and serological reaction for syphilis. In persons under thirty-five an x-ray of the chest should be made, and in persons over thirty-five a stool specimen should be examined for occult blood. With the widespread use of 35 mm. photofluorographic units, the chest x-ray may soon be covered by industrial or public health surveys. The other laboratory procedures are simple and can be entrusted to a comparatively untrained technician.

Many physicians now returning to practice after duty with the armed forces are well familiar with repeated physical examinations. To these men the technique of examination has become a routine of small moment. With a simplified history especially designed to assay the functioning of the various organ systems, and a limited number of simple laboratory procedures it is possible for many men to adapt their military experience to a fundamentally important end in civilian practice, namely, the recognition of the major fatal and disabling diseases in their earliest stages. With a suitable office layout such examinations should not be appreciably more laborious than those now required by insurance companies and should be economically profitable in their own right.

REFERENCES

1. Adams, F. D.: Cabot and Adams Physical Diagnosis, 13th Ed., Baltimore, Williams and Wilkins, 1942.

2. White B. V. and Geschickter, C. F.: Diagnosis in Daily Practice, Philadelphia, Lippincott, 1947.

REPORT OF THE BOARD OF MEDICAL VISITORS TO THE BOARD OF DIRECTORS

The Institute of Living, Hartford

During these past years, physicians have been concerning themselves with one or the other group of human ills to the extent that medical care has been divided more and more into specialties. There is a great deal to be said in favor of the concentrated study and treatment resulting from this dividing of the responsibilities and interests of medicine. Certainly recent years have seen tremendous progress in lessening the toll of sickness. However, it has also become increasingly evident that medical care can suffer insofar as any one branch of medicine becomes so highly specialized as to be separated from the knowledge and experience of the rest of medicine.

The spotlight currently being turned on these facts points up, in sharper focus, the medical wisdom that has fostered an affinity here at the Institute among the medical specialties. We recall that in 1932, your psychiatrist-in-chief recorded in his annual report that "the complete intellectual unification of psychiatry with all the other branches of medicine must be our goal if we are to be in the vanguard of progress."

The foregoing is a vivid commentary on the heritage, as well as the future, of psychiatry. We all know that the treatment of the mentally ill was long ignored by the science of medicine, and even after the birth of psychiatry, that specialty was not wholly accepted, and did not function, as a legitimate member of the medical family. For that birthright the Institute of Living has fought continuously since its reorganization seventeen years ago. Seeking advice from all branches of medicine, the Institute has brought all medical knowledge and skill to bear on the problems of nervous and mental diseases. Unquestionably, the services of the large consulting staff, combined with psychiatric knowledge, have played an important part in the successes of the Institute in returning patients to society.

While emphasizing the wealth of knowledge the other medical specialties offer psychiatric endeavors, we neither ignore nor minimize the equally important contribution that psychiatry, in its specialized understanding of the emotions, has to give the rest of medicine. The soma and the psyche, or the body and the mind, are not separate entities; they are one in sickness and in health. Any division between the two is not only artificial; it is disadvantageous to all concerned. So it is that specialization has its advantages and its disadvantages. Medical men have learned that if they would profit from the advantages without suffering the disadvantages, they must not sacrifice their unity, but rather, must strive toward the closer interlocking of all the branches of medicine.

For these reasons, the members of this Board commend your vote to erect, in the new building of the Connecticut State Medical Society, a plaque commemorating the founding of this institution by that Society, and memorializing Dr. Eli Todd, the Institute's first superintendent. To express our feelings on the subject, we quote from the minutes of one of our meetings:

"The Institute of Living, formerly the Hartford Retreat, was chartered in 1822 by the Connecticut State Medical Society, the Society emptying its treasury to do so. This institution was one of the first three hospitals in the country devoted to the treatment of nervous and mental diseases, and the first hospital of any kind in the State. As such it was one of the several outstanding accomplishments of Connecticut medicine. Thus, the Institute was fathered by the Connecticut State Medical Society, and a tablet recording the original close relationship between the two, and dedicated to strengthen and perpetuate that relationship would be most fitting."

Renewed effort "to strengthen and perpetuate that relationship" is a keynote of the most advanced medical thinking. Past experience has shown clearly that as the relationship is strengthened and perpetuated, the gain will be great, and it will be reciprocal. We congratulate you on your efforts along this line, and urge the Institute's continuing close relationship with the rest of medicine through

your consulting staff, as well as through the avenues of the State Medical Society.

We might interpolate here that our views have a sound basis in experience. We are representative of several branches of medicine, and according to long standing policy, every member of this Board has occupied the presidency or other responsible positions in the State Medical Society. When our fellow members entrusted us with the helm of the Society, they conferred upon us not only the honor and duty to contribute the best possible leadership during our tenure, but a valuable opportunity to gain a broad point of view in medical matters.

On the subject of membership of this group, we view with appreciation the decision of the Board of Directors to appoint each retiring president of the Institute of Living Medical Alumni Association as an ex officio member of the Board of Medical Visitors for a period of one year. With great pleasure we anticipate working with these graduated fellows-in-psychiatry and graduated staff members of the Institute.

It is of interest, and a source of great satisfaction and pride, to note that the Institute has grown to be two and two-thirds larger than it was when its reorganization was embarked upon April 1, 1931. Since then, each year has witnessed further realization of the visions for future development that were projected at that time. This past year has been no exception.

We are enthusiastic at the progress on the psychosurgery building, and eagerly anticipate the results that surely will be forthcoming from this endeavor. The successes derived from the postoperative reeducational program already underway are ample evidence that the Institute's pioneering ventures into this field were well founded.

With plans completed and construction begun on the child psychiatry building, the Institute is on the threshold of making another important medical contribution. In this sphere also, experience indicates future success, and our commendation is added to manifold others in urging you to spare no effort in providing this greatly needed service.

The proposal to construct an auditorium on the north side of the Research Building, with an exit on Washington Street, is important not only for the usefulness of such an auditorium in the therapeutic program, but also for its effectiveness as a vehicle for expanding the already impressive efforts of the Institute in the sphere of public and professiona education. We are thinking particularly of th excellent Conference Talks sponsored here every winter, which the greater seating capacity woul open to a large number of interested persons wh cannot be accommodated in the limited space o the Graduate Club Auditorium. Even now worl renowned, the Institute continues to grow apac with its usefulness and sphere of influence.

It was a courageous decision on the part of th Board of Directors not to raise the rates at the Insti tute, but to meet the skyrocketing cost of operatio through economies that would not lower the stand ard of care. Sickness is always a catastrophe for th average person because of the expense involved, an psychiatric illness, by virtue of the longer perio of hospitalization that is generally required, cost more than any other illness. Today, the require ments of hospital care and treatment, like every thing else, cost more than ever before, creatin serious additional problems in the administrativ sphere. Your determination to find a solution othe than adding to the patient's burden in a monetary way is an embodiment of the highest ideals in help ing the sick. The appreciation of the Institute' patients must know no bounds.

Finally, may we commend the Institute on its efficiency in building up its staff in the postwa period. As has been so consistently reiterated here at the Institute, the success of any hospital depends on the quality and quantity of the personnel. We appreciate, with you, the paramount importance of the human element in psychiatric care, particularly in achieving the aims of reeducational therapy. The careful selection and training of the staff cannot be overemphasized. Your unfailing attention to these matters is consistent with the astuteness and sense of values that have guided the Institute to the fore front of outstanding psychiatric institutions, and kept it there.

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EDITORIALS

Action Now!

This Society is about to take action once more on a plan for the prepayment of certain medical services. The new committee authorized by the House of Delegates last April recognized the immediacy of its assignment and proceeded without delay to follow the directive of the House to develop a prepaid plan including service and indemnity features, to be written by a nonprofit organization. The report of the committee and the legal documents essential to such a plan are presented in this issue and they should be studied with care by every member of the Society.

In the ten years that have elapsed since we began consideration of providing a means of voluntary insurance against the costs of medical care, plans of varying types have been put into operation in all except five or six states. That Connecticut is one of these calls for serious consideration. Why have we failed to follow the lead in this important undertaking? No physician in this state would admit that his sense of responsibility to the public, his concern for the welfare of his fellowmen, was frail in comparison with that of colleagues in other states. No one of us would tolerate the charge that the prestige of medicine here, in the minds of the people or of the profession elsewhere, was of little moment to us.

We cannot deny, however, that for almost a decade, we have procrastinated and hesitated and acted in general with slight resolution. It may be that the explanation lies in our refusal to recognize that any project of this kind is of necessity experimental. It is obviously not possible to start with a flawless plan that will operate perfectly immediately, at all times, and under all circumstances. Changes must be made in every plan as experience is gained and this is particularly true of the schedule of indemnities. If we are not willing to accept the fact that the essential thing is to get under way and make corrections as we go, we may as well forget the whole matter now and not waste more years in fruitless debate.

We have one more chance to show that we are not less decisive than our peers. Let us put away our fear thoughts and our small self-interest, if any there be, and make these benefits available to the people of Connecticut.

To Know What We Are Talking About

With all the discussion of medical care problems a variety of meanings have been given to various aspects of medical care. In an effort to determine the definition of generally accepted medical terms the Council on Medical Service of the AMA will submit the following definitions for consideration to the House of Delegates at the St. Louis session.

SOCIALIZED MEDICINE

Socialized medicine is a system of medical administration by which the government promises or

attempts to provide for the medical needs of the entire population or a large part thereof.

STATE MEDICINE

State medicine is a form of socialized medicine in which the government attempts to provide medical services directly to the general population from funds established by taxation. The physicians become employees of the state and medical practice becomes subject to the directives of the third party.

SICKNESS INSURANCE

Sickness insurance is ostensibly a method of transferring the economic burden of sickness from the individual to the group. Sickness insurance may be voluntary or compulsory.

COMPULSORY SICKNESS INSURANCE

Compulsory sickness insurance is a system of sickness insurance in which all members of a given group of persons in a given governmental area are compelled by law to contribute to and be enrolled in the scheme. Any compulsory sickness insurance program under direct control of the state is socialized medicine, insurance principles no longer prevail and the compulsory contributions become a special tax.

VOLUNTARY SICKNESS INSURANCE

Voluntary sickness insurance is that system whereby individual costs are spread over a period of time by a group of people who voluntarily band together to protect themselves against the economic burden of sickness. It involves the insurance principle and an organized system of payment. It is popularly known as voluntary prepayment medical care insurance.

PUBLIC HEALTH

Public health includes those arrangements whereby the government provides medical services for special groups of persons and undertakes activities which are concerned with the protection of the health of the people as a whole. Public health is concerned with persons requiring institutionalized care, with those who are wards of the government, with the indigent, with proper sanitation, and with the control and prevention of communicable diseases.

HEALTH INSURANCE

Health insurance is used interchangeably with sickness insurance and usually means the same thing. It may be voluntary or compulsory, although national health insurance usually means compulsory sickness insurance.

GROUP MEDICAL PRACTICE

Group medical practice is the provision of medical service by a number of physicians working in systematic association with the joint use of equipment and technical personnel and with centralized administration and financial organization.

PRIVATE GROUP CLINICS

The term private group clinics applies to organizations owned and managed by one or more physicians offering medical services. Services are usually supplied by a number of physicians who practice as a group, using joint office facilities and equipment. The physicians are under the supervision of a medical director.

Hospital Practice and the General Practitioner

Among the factors which have brought about an increased attention to the role of the general practitioner are (1) the great trend toward specialization and (2) the adoption by hospitals of regulations restricting medical practice. There is little doubt that the trend toward specialization is influenced by the tendency of some hospitals to limit staff appointments to physicians with Board certification. The position of organized medicine in this matter has been clearly stated,[1] "Any rule barring a physician from staff privileges because he does not possess a certificate from one of the specialty boards or membership in a special society is not in accord with the expressed policy of the American Medical Association and the Advisory Board for Medical Specialties. Hospital staff appointments should depend on the qualifications of physicians to render proper care to patients as judged by the professional staff of the hospital and not on certification or special society membership."

With the great expansion of hospital and medical insurance there is bound to be an increased demand for medical care in hospitals. For the general practitioner to be forced to relinquish care of a patient because of hospital regulations may cause not only confusion in the mind of the public but injustice in individual cases. While it is true that restriction of hospital practice to specialists in some instances may serve to protect both hospital and patient, to establish rules incapable of flexibility is not conducive to

good public relations. In reply to a recent questionnaire on this subject sent to New England hospitals, the following reply from a 480 bed general hospital reflects sound thinking and practice. "General practioners may be appointed to any position in our hospital by the Board of Trustees on the recommendation of the Staff Advisory Committee which considers their general and specialized qualifications. There is no staff rule or regulation which prohibits the general practitioner from participating in any activity on the service to which he is assigned if he is considered qualified by the chief of the service.

"In practice, the general practitioner or the so-called 'Specialist' who does not limit his practice may be promoted to a position on our staff in any medical or surgical specialty provided he has demonstrated that he is qualified for the position. Accordingly, there are instances in our staff where men, who must be technically called general practitioners, have achieved the rank of seniors in specialty services.

"Usually the man with a house service in our hospital limits his practice in the hospital to that service although he may practice general medicine outside of the hospital. There are very few instances where men who are not classified as obstetricians deliver babies in the hospital and yet are members of other specialty services. In practice there are becoming fewer as time goes on." In considering this question the *Rhode Island Medical Journal* recently made this comment.[2] "The ramifications of this problem are many. The issue is one that can work to the disadvantage of organized medicine at a time when strength and unity of membership is of paramount importance. The public seeking medical service has every reason to be concerned with the regulations for the staffing of hospitals wherein an increasing amount of that service may be given in the future.

"The suggestion appears worthy of consideration that the Council of the New England State Medical Societies establish a committee of its own, or for it, to make a complete study of this situation in the New England area in order to rationalize in this region what might be done in the best interests of the public and the profession to give the general practitioner hospital privileges."

1. J.A.M.A. 134:1484, 1947.
2. R.I.M.J. August 1948, p. 500.



The Connecticut Plan for Indigent Care

The plan to assure adequate medical care for indigent citizens of Connecticut, which was published in the November issue of this JOURNAL, is a social instrument of more than local importance, for it shows what can be done when alert state officials call upon the cooperation of a professional group. This plan, in which a state will give really adequate medical care to its own people, is a forceful and proper answer to those who would scrap the potentialities of our present system for one which would make every doctor's patient a ward of the national government.

The report of the committee headed by Dr. Cole B. Gibson, as the Society's representative, makes specific mention of the "medically indigent," a relatively new concept to which the rapid changes in our economy which characterize the present day can frequently, when coupled with catastrophic illness, reduce the economic status of the individual almost over night. This is in contrast to the thinking of former years which perhaps considered state aid too often upon the concept of pauperism. This feature is an important part of the plan, and it enables the individual to seek aid prior to being reduced to the lowest possible economic status.

The plan gives further assurance of the recognition by our State of responsibility to its people, a responsibility which without question reflects the thinking of the majority of our citizens. This principle of self-help, which was ingrained in our people at the beginning of their history, was recognized many years ago when Connecticut came to be known as "the land of steady habits." To preserve this fine principle in the social aspects of medical care calls for a continued awareness on the part of both laity and profession of the great potentialities in our present system for the solution of common problems.

PROGRESS IN CLINICAL MEDICINE

CRITIQUE ON VAGOTOMY

ALFRED HURWITZ, M.D., *Newington*

IN 1814 Brodie[1] published the results of vagal resection in the dog. In a comprehensive historical review Small[2] stated that the first division of the vagus nerve performed in man for ulcer (only the left vagus was divided) was reported in 1912 by Exner and Schwarzmann. In 1930 Pieri and Tanferna performed bilateral subdiaphragmatic vagal division in eight patients. Since Dragstedt[3] published a description of the technic of supradiaphragmatic resection in 1943, a voluminous literature pertaining to this subject has appeared. The consensus of opinion is that the efficacy of the operation may be attributed to (1) diminished gastric secretion, (2) diminution in gastric motility, and (3) lack of response of the gastric mucosa to emotional stimuli.

GASTRIC SECRETION

Although Sandweiss[4] found normal values in patients with chronic duodenal ulcers, many investigators have found the gastric secretion in ulcer patients to be above normal in quantity and acidity. Griswold[5] emphasized the fact that the digestive activity of gastric secretion was due to both hydrochloric acid and pepsin. Schiffrin and Ivy[6] were unable to produce ulcers in dogs by constant stimulation with acid alone but were successful when a combination of pepsin and acid was used. Since vagal resection militates against the effect of the cephalic phase of gastric secretion only, it will not prevent the development of an ulcer caused by histamine stimulation in dogs, according to Wangensteen.[7] Oliver[8] performed vagal divisions before the establishment of a Mann-Williamson anastomosis in five dogs, all of which died of perforated ulcers. It has been impossible thus far to simulate in dogs the emotional, cephalic phase of gastric secretion that plays a role in the pathogenesis of ulcer in humans.

The evidence that the diminution in gastric secretion after vagotomy is only transitory is incontrovertible. The dogs which had had bilateral vagal resections performed by Hartzell[9] were found to have normal values for gastric acidity by Vanzant[10] two to three years later. Moore[11] stated, "In our experience demonstrable changes at the organic level in the resting, unstimulated stomach have for the most part disappeared by the end of one year." He also cast doubt concerning the authenticity of the insulin test since serial tests had shown variations in the same patient.

GASTRIC MOTILITY

Although there is some difference of opinion concerning whether vagal stimulation causes increase in contractility of the stomach, there is no confusion concerning the effect of vagal division. In most cases there is a marked diminution in hunger contractions and a delay in initial and complete emptying times. In a personal series comprising seven cases, five of the patients retained barium in their stomachs 18 to 24 hours after ingestion in the early postoperative period. The gastric atony is often associated with diarrhea, according to Moore.[11] He stated that the gastric motility in most of his patients returned to normal within one year after vagotomy.

EMOTIONAL STIMULATION

Lack of response of the gastric mucosa to emotional stimuli represents the only possible lasting effect of vagotomy. Andrus[12] described Wolff and Wolf's observations made through a gastrostomy

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opening in a patient with an obstructing carcinoma of the esophagus. Mention of the name of the doctor who first treated him made him enraged and the gastric mucosa became engorged and hyperemic. After a transthoracic operation at a later date revealed an inoperable malignancy, both vagi were divided supradiaphragmatically. Following this operation resentment on the part of the patient failed to change the appearance of the gastric mucous membrane. One of our patients had repeated exacerbations of a duodenal ulcer, obviously related to periods of emotional stress. After division of the vagi he performed a more arduous and exhausting job as a travelling salesman with complete absence of ulcer symptoms for the sixteen months during which he was followed. However, there has been a definite change in affect. Situations which previously evoked epigastric distress now produce anxiety without organic symptoms.

INDICATIONS FOR VAGAL RESECTION

The indications may be classified under five headings.

Group I. This group would comprise those ulcer sufferers whose attacks seem related to tense emotional incidents and who cannot avoid recurrences. In other words, these patients have a more pronounced response to the cephalic phase of gastric stimulation than to the gastric or intestinal phase. In our group of seven patients who had had transthoracic vagotomies, all had complete alleviation of symptoms from four to sixteen months after vagal division. The efficacy of the operation is more likely to be manifested in the young adult, i.e., under 40 years of age, who show strongly positive insulin reactions.

Group II. Patients who have developed ulcers following adequate partial gastrectomy with removal of the entire antrum or gastroenterostomy fall into this group. Secondary resections carry such a high mortality and vagotomy, according to Dragstedt[13] and Weinstein and Colp,[14] has been so successful that the choice of the latter procedure seems desirable. However, in one of our patients vagotomy performed for a marginal ulcer was followed by the occurrence of a gastric ulcer. This case will be described in detail below.

Group III. The indications for vagotomy alone in the treatment of patients with recurrent bleeding are less clearcut. It is doubtful that this operation can promote complete healing of a calloused ulcer, a common finding in the arteriosclerotic patient suffering from repeated hemorrhages. Most surgeons would advocate resection of the ulcer with most of the stomach, preferably in the stage of remission. Subdiaphragmatic vagotomy and partial gastrectomy might prove to be the procedure of choice if Lahey's[15] experience is corroborated by other clinics. He stated that 28 in a series of 100 patients with bleeding duodenal ulcers showed recurrences of hemorrhage after partial gastrectomy.

Group IV. Lahey[15] also suggested that vagotomy might be more desirable than resection in the surgical treatment of low-lying duodenal ulcers in close proximity to the common bile duct.

Group V. Patients with high gastric ulcer combined with a duodenal ulcer comprise this group. Total gastrectomy for high gastric ulcers is a formidable procedure and carries an appreciable mortality and morbidity rate. Since the incidence of malignancy in gastric ulcers when combined with a duodenal ulcer is so low (1 in 938),[16] the indication for resection becomes less clearcut. A transthoracic vagotomy may prove to be the procedure of choice in the treatment of many of these patients.

CONTRA-INDICATIONS TO VAGOTOMY

1. *Psychoneurotic* or frankly psychotic patients whose symptoms for the most part are unrelated to the ulcer.

2. *Acute bleeding ulcers.*

3. *Cicatricial obstruction.* If the patient's physical condition is satisfactory, partial gastrectomy has been considered preferable to a gastro-enterostomy because the ulcer can be removed and the possibility of the development of a marginal ulcer reduced. When the patient's condition is so poor that only a gastro-enterostomy is indicated, it would seem unwise to combine this procedure with a vagotomy.

4. *Gastric ulcers.* Harper and Dragstedt[17] advocated vagotomy followed by a partial gastrectomy four to six weeks later if the ulcer failed to heal in the interim. This line of approach has little to commend it since the roentgenologist may be guilty of a 20 per cent error in his ability to differentiate between a benign and a malignant lesion. Furthermore, partial gastrectomy for ulcer in the distal half of the stomach should carry less than a 1 per cent mortality. A final argument in favor of resection is that the surgeon may have a false sense of security when the ulcer diminishes in size. Jordan[18] reported two cases in which a malignant ulcer became smaller on

successive x-rays, due to a subsidence of the inflammation about the carcinoma. Resection of the stomach is indicated, especially in patients over forty years of age with a brief ulcer history and with anacidity.

5. *Hypertension.* In patients with hypertension there is the theoretical possibility that division of the vagi might cause an exacerbation of the hypertensive state.

POSTOPERATIVE COMPLICATIONS

1. *Incisional pain.* Moore[19] reported intercostal pain in 55 per cent of the patients operated by the transthoracic route. Johnson[20] advocated dividing two intercostal nerves above and two below the rib removed as close to the vertebral column as possible. We have noticed diminution in the degree of intercostal pain after dividing the involved nerve in the region of the posterior sensory ganglion.

2. *Gastric atony.* This complication may prove most distressing in the immediate postoperative period. According to Moore[19] 56 per cent of his patients had transient fullness postoperatively, 5 per cent fullness with eructation, 8 per cent fullness and vomiting as major symptoms. The untoward effects of atony may be obviated by Wangensteen drainage of the stomach during the first four or five days after operation. Urecholine has been employed by Machella[21] to combat this complication with gratifying results. If candidates for vagotomy are carefully selected, the use of urecholine and Wangensteen gastric drainage should make gastroenterostomy rarely necessary.

3. *Diarrhea.* In our series (7 supradiaphragmatic and 13 subdiaphragmatic vagotomies) no patient had severe, intractable diarrhea after vagotomy, but approximately 50 per cent of each group had transient diarrhea consisting of 4 to 5 loose bowel movements lasting one to two days and occurring every four to six weeks. Moore[19] reported that 6 per cent of his patients had major and persistent diarrhea and 62 per cent had frequent loose stools of varying severity. He felt that the fecal frequency was usually associated with gastric atony and that the correction of the latter resulted in an amelioration of the former.

4. "*Nervous loading.*" Moore[19] applied this term to those patients who had a feeling of nervousness at the times when previously their ulcers would have been symptomatic.

5. *Cardiac arrest.* The possibility of initiating a vagovagal reflex during the dissection of the vag may be obviated by the use of atropine and intravenous procaine.

6. *Achalasia.* Moses[22] reported one case in which cardiospasm was encountered after vagotomy and was relieved following injection of the celiac ganglion with bromsalizol.

7. *Silent perforation of the ulcer.* Weeks[23] reported deaths in two patients who had dorsolumbar sympathectomy for hypertension and vagotomy for duodenal ulcer because of unrecognized perforation. This complication occurred in one patient studied by Bergen and Kintner.[24] It is difficult to understand how the abdominal findings consistent with peritonitis were absent since they depend on the transmission of afferent impulses along the somatic nerves.

8. *Failure of ulcers to heal and development of new ulcers.* Moore[19] reported a single recurrence of a duodenal ulcer in his series of 74 cases. In a personal communication Walters stated that his recurrence rate was two out of approximately fifty cases although ulcers were present by x-ray approximately two and one-half weeks after operation in 6 patients in a series of 68 cases. Two of the 6 patients showed no free hydrochloric acid after intravenous injection of 20 units of insulin, i.e., a negative insulin test. Colp[25] reoperated on one patient in a group of 21 who had symptoms two months after vagotomy despite a negative insulin secretion test. At operation an active ulcer on the posterior wall of the duodenum was found. Dragstedt[13] reported 5 recurrences in a group of 212 patients. In each of the 5 cases insulin tests revealed incomplete division of the vagi. Reoperation on two patients revealed a single intact vagal filament which was divided with subsequent amelioration of symptoms.

One of our patients developed a gastric ulcer following vagotomy for a gastrojejunal ulcer. The case report follows:

CASE REPORT

G. C. U., a fifty-year-old male, entered the hospital in October 1946. The past history revealed that he had had ulcer symptoms for thirty years. In 1925 a posterior gastroenterostomy was performed at another hospital and was not followed by any amelioration of his symptoms.

X-ray revealed a duodenal deformity and an irregularity of the stoma suggestive of a marginal ulcer. A supradiaphragmatic vagotomy was done in November 1946. The patient was asymptomatic for only four months when he complained of severe pain in the left upper quadrant of the abdomen radiating to the back. This new symptom was so

persistent that the patient was readmitted to the hospital in December 1947. Roentgenological examination revealed a contracted stomach with marked enlargement of the rugal folds. The barium suspension passed through both the gastrojejunostomy and the pylorus. In the pars media there was a persistent ulcer crater from which radiating folds extended peripherally. The duodenal cap was markedly deformed. The insulin test showed no free acid on two occasions. On February 14, 1948 four-fifths of the stomach was removed together with a gastric ulcer, one inch in diameter, near the lesser curvature and the scarred first portion of the duodenum. A new anastomosis was made between the remaining pouch of stomach and the jejunum. No marginal ulcer was found in the specimen. He made a satisfactory convalescence and was discharged on the twentieth postoperative day.

The development of a gastric ulcer after vagotomy, although rare, militates against the efficacy of the operation. In a personal communication Walters stated that he had one such experience and a recurrence of a large gastric ulcer in another patient after excision and vagotomy had been previously performed.

DISCUSSION

Vagotomy must vie with partial gastrectomy in the treatment of duodenal ulcer. Although the mortality associated with the former procedure is about 1 per cent (only 0.5 per cent in Dragstedt's series) as opposed to about 2 to 4 per cent in the gastrectomy group, the incidence of recurrence of symptoms, the development of distressing complications, and the necessity for secondary operations are more pronounced in the vagotomy group.[25,26,27]

The indications for vagotomy are becoming more limited. The postoperative complications have been so distressing and frequent that several investigators[28,29] have called for a moratorium for 5 years so that the present series can be properly evaluated. An analysis of Moore's[19] statistics reveal that 87 per cent of the patients in his series had results that were satisfactory to them. Only 7 per cent had poor results and only one had a recurrence of the ulcer. Of the 13 patients who had only fair results, 2 required a posterior gastroenterostomy, 2 had postoperative gastrointestinal bleeding, 4 had transient ulcer pain and 5 had fullness and diarrhea. Five of Colp's[25] 21 patients were subjected to reoperation. Only one had a recurrent ulcer but in four the motor disturbances were so severe that "the patients begged for relief because of epigastric distress, vomiting and the belching of foul gas." These symptoms were relieved by partial gastrectomy in 3 cases, and a gastroenterostomy in 1. Colp has ceased performing vagotomy as a sole procedure in the treatment of duodenal ulcer.

Several surgeons[26,27] have advocated combining posterior gastroenterostomy with vagotomy. It is difficult to justify the employment of gastroenterostomy after that operation has been discarded because of its many failures. As Boles[28] justly states, "I cannot understand by what magic all the previous hazards of gastroenterostomy will suddenly be dissolved by doing a vagotomy." The argument for employing vagotomy with partial gastrectomy is a more cogent one. This combined operation may prove efficacious in the prevention of bleeding which, according to Lahey, is so likely to occur after partial gastrectomy for a bleeding duodenal ulcer. In our series of thirteen cases subjected to both procedures, the incidence of epigastric fullness, annoying distention, vomiting and diarrhea was 54 per cent. The postoperative stay in the hospital was increased from fifteen to twenty-one days. Although these patients have been relatively asymptomatic since discharge from the hospital, the high incidence of distressing symptoms in the early postoperative period argues against widespread use of these combined operations. Furthermore there is no assurance that the addition of vagotomy will lower the incidence of marginal ulcer which is only 5 per cent or less after partial gastrectomy.

CONCLUSIONS

1. A critique on vagotomy has been presented.

2. The development of a gastric ulcer following complete vagotomy for marginal ulcer has been described.

3. The limitations and complications of this operation should be recognized.

4. The selection of patients for vagotomy will eventually depend on the determination that the cephalic phase of gastric secretion exceeds in importance the hormonal and other phases of secretion.

BIBLIOGRAPHY

1. Brodie, B. C.: Experiments and Observations on the Influence of the Nerves of the Eighth Pair on the Secretions of the Stomach. Phil. Tr., London 104:102-106, 1814.

2. Small, J. T.: Denervation of the Stomach. Arch. of Surg., 55:189-203, 1947.

3. Dragstedt, L. R., and Owens, F. M., Jr.: Supradiaphragmatic Section of Vagus Nerves in the Treatment of Duodenal Ulcer. Proc. Soc. Exper. Biol. & Med. 53:152-154, 1943.

4. Sandweiss, D. J., Sugarman, M. H., Podolsky, H. M., and Friedman, M. H. F.: Nocturnal Gastric Secretion in Duodenal Ulcers: Studies on Normal Subjects and Patients with Their Bearing on Ulcer Management. J.A.M.A. 130:258-265, 1946.

5. Griswold, R. A.: Discussion on Vagotomy. Arch. Surg. 55:204, 1947.

6. Schiffrin, M. J., and Ivy, A. C.: Physiology of Gastric Secretion, Particularly as Related to the Ulcer Problem. Arch. Surg. 44:339-413, 1942.

7. Wangensteen, O. H.: Discussion on Vagus Section. Annals of Surg. 126:705, 1947.

8. Oliver, I. V.: Effect of Vagotomy on Development of Mann-Williamson Ulcer in the Dog. Arch. Surg. 55:180-188, 1947.

9. Hartzell, J. B.: Effect of Section of Vagus Nerves on Gastric Acidity. Am. J. Physiol. 91:161-171, 1930.

10. Vanzant, F. R.: Late Effects of Section of Vagus Nerves on Gastric Acidity. Am. J. Physiol. 99:375-378, 1932.

11. Moore, F. D., Chapman, W. P., Schulz, M. D., and Jones, C. M.: Resection of the Vagus Nerves in Peptic Ulcer. J.A.M.A. 133:741, 1947.

12. Andrus, W. De W.: Discussion on "Vagus Section in Peptic Ulcer." Annals of Surg. 126:703, 1947.

13. Dragstedt, L. R., Harper, P. V., Tovee, E. B., and Woodward, E. R.: Section of the Vagus Nerves to the Stomach in the Treatment of Peptic Ulcer. Annals of Surgery 126:687-699, 1947.

14. Weinstein, V. A., and Colp, R.: Supradiaphragmatic Vagotomy in Gastrojejunal Ulceration Following Subtotal Gastrectomy for Duodenal Ulcers. S. Clin. North America 27:249-253, 1947.

15. Lahey, F. H.: Discussion on "Vagus Section in Peptic Ulcer." Annals of Surg. 126:701, 1947.

16. Fischer, A., Clagett, O. T., and McDonald, J. R.: Coexistent Duodenal Ulcer and Gastric Malignancy. Surgery 21:168-174, 1947.

17. Harper, P. V., and Dragstedt, L. R.: Section of the Vagus Nerves to the Stomach in the Treatment of Benign Gastric Ulcer. Arch. Surg. 55:141-150, 1947.

18. Jordan, S. M., and Smith, F. H.: A Study of Gastric Ulcer. Presented at American Gastroenterological Association Conference, Atlantic City, 1948.

19. Moore, F. D.: Vagus Resection for Ulcer: An Interim Evaluation. Annals of Surg. 126:664-678, 1947.

20. Johnson, J.: Post-Operative Pain Following Total Pneumonectomy. J. Thor. Surg. 12:697-703, 1943.

21. Machella, T. E., Hodges, H. H., and Lorber, S. H.: The Restoration of Gastric Motility by Urethane of B-Methyl Choline After Section of the Vagus Nerves for Peptic Ulcer. Gastroenterology 8:36-51, 1947.

22. Moses, W. R.: Critique on Vagotomy. New Eng. J. Med. 237:603-610, 1947.

23. Weeks, C., Ryan, B. J., and Van Hoy, J. M.: Two Deaths Associated with Supradiaphragmatic Vagotomy. J.A.M.A. 132:988-990, 1946.

24. Bergen, H. M., and Kintner, A. R.: Aggravation of Gastric Ulcer Following Dorsolumbar Sympathectomy. J.A.M.A. 133:1207-1208, 1947.

25. Colp, R.: Discussion on Vagotomy. Annals of Surg. 126:699-701, 1947.

26. Grimson, K. S., Baylin, G. J., Taylor, H. M., Hesser, F. H., and Rundles, R. W.: The Effects of Transthoraeic Vagotomy in 57 Patients with Peptic Ulcer—Clinical Limitations. J.A.M.A. 134:925, 1947.

27. Walters, W., Neibling, H. A., Bradley, W. F., Small, J. T., and Wilson, J. W.: Results of Vagus Nerve Rescetions in Treatment of Peptic Ulcer. J.A.M.A. 136:742-747, 1948.

28. Boles, R. S.: Modern Medical and Surgical Treatment of Peptic Ulcer. J.A.M.A. 136:528-534, 1948.

29. Bockus, H. L., Recent Advances in Treatment in Field of Gastroenterology. J.A.M.A. 136:293-297, 1948.

HOUSE OF DELEGATES

SEMI-ANNUAL MEETING

NEW HAVEN MEDICAL ASSOCIATION BUILDING

364 Whitney Avenue, New Haven

THURSDAY, DECEMBER 9, 2:00 P. M.

Note Change in Time of Meeting

THE PRESIDENT'S PAGE

Now that the tumult and shouting is over and the die has been cast for the ensuing four years, it is well that the medical profession in Connecticut as well as elsewhere take serious thought as to the implications involved.

The interpretation by those that have been elected to office will be, and it is a plausible one, that the voters have expressed a desire for a shift toward positive governmental action with a view to improvement in the general welfare. As concerns health and medical service, action is imminent and will undoubtedly be pushed with the greatest vigor. The time has now passed for indifference or indecision on the part of the physician, whether he be in favor of this or against it.

Above all, he must not, individually or as a group, allow himself to be found in the position of placing his own welfare above that of the common-weal. A general resistance, whether passive or active, will carry with it this interpretation which can only be dispelled by notable evidence of positive concern on his part for the public welfare. The physician should no longer in this respect avoid publicity, but should, on the contrary, in his own community and in conjunction with his colleagues at the county and state levels diligently search for ways of demonstrating his concern, not only for the well-being of his own patients but also for that of the public at large. By doing this the latter may be convinced that improvement in health and medical services can be accomplished better, in Connecticut at least, by an orderly development in conjunction with an intelligent and interested medical profession, rather than under an over-all comprehensive and obligatory plan.

Samuel C. Harvey, M.D.

THE SECRETARY'S OFFICE

CREIGHTON BARKER

GRACE MOONEY
Executive Assistant

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Public Relations

258 CHURCH STREET, NEW HAVEN
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NOVEMBER COUNCIL MEETING

Budget and Dues 1949

The treasurer, Dr. Gibson, presented the budget for 1949 as proposed by the Budget Committee and explained that it was based upon dues assessment for the State Society of $25. The Council approved the budget and the dues.

Committee Appointments

On request from the Committee on Industrial Health, the Council appointed Dr. J. Wister Meigs, New Haven, as a member of that committee.

On request from the Committee to Study the Medical Examiner System, the Council appointed Dr. William T. Salter, New Haven, and Dr. Robert Tennant, Hartford, as members of that committee.

Coroner and Medical Examiner System

Consideration was given to a resolution from the Middlesex County Medical Association concerning modernization of the office of Coroner. It was voted to refer the recommendations from Middlesex County to the Committee on the Medical Examiner System.

Headquarters Building Progress

It was reported that working specifications for the headquarters building of the Society were ready to be let out to contractors for estimates and that these estimates should be submitted to the Board of Trustees of the Building Fund and then sent to the Council before final decision.

State Department of Health Chronic Disease Service

A proposal of the State Department of Health that it subsidize extension of tumor clinic services to include diagnosis of other chronic diseases was discussed at length. The Council voted to refer this entire matter for careful study to the Society's Committee on the Chronically Ill.

American Medical Association General Practitioner Award

The secretary presented biographical material on the following physicians nominated by their respective County Medical Associations for the General Practitioner Award:

Fairfield County—Dr. J. Howard Staub, Stamford.

Hartford County—Dr. Oran A. Moser, Rocky Hill.

Litchfield County—Dr. W. Bradford Walker, Cornwall.

Windham County—Dr. Ernest R. Pike, East Woodstock.

Dr. Walker wished to withdraw as a nominee, but the chairman ruled that this could not be done and Drs. Walker and Miller left the room during the voting by closed ballot. Dr. Ernest R. Pike was selected as the nominee from this Society for the award.

New Haven County Disapproves General Practitioner Award

At its Semi-Annual Meeting in October the New Haven County Medical Association took action on the Annual Award of a General Practitioner Medal by the American Medical Association. The Association went on record as opposed to any attempt to select annually, on a geographic basis, the outstanding general practitioner of that area. It voted not to nominate a candidate for the award from the Association and instructed its Councilor, Dr. Courtney C. Bishop, to inform the Council of this action. It further voted to ask the delegates from the Connecticut State Medical Society to the American

Medical Association to present a resolution, expressing the opposition of the New Haven County Medical Association to this project, at the Interim Session of the House of Delegates of the American Medical Association in St. Louis, November 30 - December 2, 1948. The Association also requested that this matter be brought before the House of Delegates of the Connecticut State Medical Society at its Semi-Annual Meeting on December 9, 1948.

It was explained that a resolution from a component county association could not be introduced by delegates from a State Society before the House of Delegates of the American Medical Association, because such a resolution would not represent the attitude of the entire State Society, and it was further pointed out that, in order to effect such presentation of a resolution before the AMA House of Delegates, action upon it must be taken by the House of the State Society. If the New Haven County Medical Association wishes to pursue this matter, it should introduce a resolution, stating its position on the award, before the meeting of the House of Delegates of this Society on December 9, 1948 and subsequent procedure will be contingent upon the adoption or rejection of the resolution by that House.

Student Members Elected

Nine student members were elected by the Society:

William H. Baird, Fairfield
Tufts College Medical School—Class of 1952
Pre-Med: Brown University
Parent: Frank H. Baird

Richard E. Bartman, Hartford
Harvard Medical School—Class of 1952
Pre-Med: Wesleyan University
Parent: John H. Bartman

Charles W. Chace, Middletown
Yale University School of Medicine—Class of 1952
PreMed: Wesleyan University
Parent: Charles R. Chace

Marvin H. Goldberg, Stamford
Yale University School of Medicine—Class of 1952
Pre-Med: Yale University
Parent: Isaac Goldberg

Hershel W. Libo, Norwich
Tufts College Medical School—Class of 1952
Pre-Med: Tufts College
Parent: Louis Libo

Arnold K. Maislen, D.D.S., Hartford
Yale University School of Medicine—Class of 1952
Pre-Med: N. Y. U.
Parent: Samuel Maislen, M.D.

Philip K. Nelson, East Norwalk
University of Pennsylvania—Class of 1952
Pre-Med: University of Pennsylvania
Parent: George P. Nelson (deceased)

Henry M. Williams, Farmington
Yale University School of Medicine—Class of 1952
Pre-Med: Yale University
Parent: Staunton Williams

Seymour Zoger, Norwich
Yale University School of Medicine—Class of 1952
Pre-Med: Yale University
Parent: Max Zoger

New Members Elected at the Semi-Annual Meetings of the County Associations

FAIRFIELD COUNTY

Richard T. Atkins, Jr., Stamford
Roy N. Barnett, Norwalk
John D. Boton, Greenwich
James R. Dickenson, New Canaan
William I. Glass, Bridgeport
Alvin I. Goldfarb, Newtown
Paul H. Harwood, Jr., Bridgeport
Maurice Kaufman, Bridgeport
George Kraus, Fairfield
Michael Luciano, Bridgeport
Sydney Luria, Bridgeport
Atrhur G. Mack, Bridgeport
Leonard Maidman, Wilton
Frederick P. McIntyre, Stamford
John G. Murray, Greenwich
John C. Olsavsky, Bridgeport
Sanford Savin, Bridgeport
Robert M. Steel, Stratford
Marion Sulzycki, Bridgeport
Ralph J. Szur, Bridgeport
Ernest A. Terry, Bridgeport
John M. Walker, Greenwich
Ellwood Weise, Jr., Bridgeport

HARTFORD COUNTY

Louis C. Acqua, East Hartford
Aloys G. Ansprenger, Newington
Donald G. Bard, Suffield
Arnold Becker, Bristol
James M. Bunce, Hartford

John E. Cartland, Jr., Hartford
Rinaldo J. Cavalieri, Newington
Joseph C. Clifford, Hartford
Elizabeth Cornfield, New Britain
Joseph M. Danyliw, East Hartford
Jacob Dorfman, West Hartford
Fleur Foohey, Hartford
Dwight Griswold, Hartford
Harry H. Hershman, Bristol
Miriam Liberson, Hartford
William T. Livingston, New Britain
Howard J. Lockward, Manchester
Vincent F. Longo, Forestville
Rocco S. Marino, Bristol
Edward Martin, New Britain
David W. Moser, Hartford
Harriett E. Northrup, Hartford
Paul S. Pizzo, Hartford
Henry M. Pollock, Jr., Bristol
William F. Prestley, Hartford
Richard M. Ralston, Hartford
Jacques Robbins, Thompsonville
Charles E. Roh, Hartford
Josef S. Silbermann, Hartford
Harvey H. Sirota, Newington
John W. Teahan, Hartford
Gideon R. Wells, Hartford
Andrew S. Wesoly, New Britain
Benjamin Wiesel, Hartford
Mario H. Yannello, New Britain
Henry M. Young, New Britain
Norman Zeldis, Hartford

LITCHFIELD COUNTY

George L. Cushman, North Woodbury

MIDDLESEX COUNTY

Asher L. Baker, Portland
Walter R. James, Essex
John J. Korab, Middletown
Bertram E. Marks, Middletown
Aldo B. Santiccioli, Middletown
Poe-Eng Yu, Middletown

NEW HAVEN COUNTY

Frederick C. Biehusen, New Haven
John Burbank, Meriden
Gregory K. Dwyer, New Haven
Harry Klein, New Haven
Stanley A. Leavy, Hamden
Charles F. Scholhamer, New Haven
Frederick W. Shull, New Haven
Ellsworth J. Smith, Madison
John R. Steeper, New Haven
Morris A. Wessel, New Haven

NEW LONDON COUNTY

Milton Fabricant, New London
John J. Gager, New London
Joseph M. Ganey, Jr., New London
William M. Konikov, Norwich
Louis R. Orkin, Norwich
Spurgeon M. Wingo, Norwich

WINDHAM COUNTY

E. Arthur Barry, Jr., Plainfield
Fred C. Collier, Willimantic
James W. Major, Willimantic
Richard V. Newcombe, Willimantic
Joseph E. Nowrey, Mansfield
Edward V. Stevenson, Jr., Thompson

Meetings Held During November

Monday, November 1, 5:00 P. M.
Committee on Arrangements, Annual Meeting, New Britain

Wednesday, November 3, 7:00 P. M.
Committee on Industrial Health

Thursday, November 4, 3:00 P. M.
Committee on Public Health

Tuesday, November 9, 4:00 P. M,
Council of the Society

Thursday, November 11, 4:00 P. M.
Executive Committee of the Committee on Tumor Study

Monday, November 15, 5:00 P. M.
Committee on Cooperation with the Yale School of Medicine

Wednesday, November 17, 4:00 P. M.
Committee on Maternal Mortality and Morbidity

Friday, November 19, 4:00 P. M.
Committee on the Improvement of the Patient

Monday. November 22, 4:00 P. M.
Program Committee, Annual Meeting

Tuesday, November 23, 3:30 P. M.
Executive Meeting, Connecticut Medical Examining Board

Meetings Scheduled for December

Thursday, December 9, 2:00 P. M.

Semi-annual meeting of the House of Delegates, New Haven Medical Association.

Thursday, December 16, 3:00 P. M.

Committee on Public Health

The Yale Medical Library Associates

A new organization known as the Associates of the Yale Medical Library has been formed in order that the vast source of medical reference material in the Yale Medical Library may become more available to physicians outside of the medical school. Invitations to membership are being sent out to Connecticut doctors and to the Yale medical alumni. At a recent organizational meeting Dr. Herbert Thoms, professor of obstetrics and gynecology, was elected chairman. Other officers are: Dr. Levin L. Waters, assistant professor of pathology, secretary; Laurence G. Tighe, treasurer of Yale University, treasurer; and Dr. George Blumer, David P. Smith clinical professor emeritus of medicine and former dean of the Yale School of Medicine, honorary chairman.

The Associates of the Yale Medical Library are granted borrowing privileges of the Library and will receive its bulletins, including accession lists and notices of important meetings. To expand further the facilities and services of the Library, the Associates are required to pay a small annual subscription fee and are urged to contribute books and other pertinent materials that will enhance the Library. The patrons of the Yale Medical Library, similar in purpose to the Associates, was founded about 1942 and was active for two years before lapsing because of the increased demands of war work. The new group has been favorably received, Dr. Thoms says, and he expects that its membership will grow continually through the years.

The Yale Medical Library has a history of support by loyal friends. Its medical holdings date back to the 18th Century when Jeremiah Dummer, while serving as Colonial Agent for the Connecticut Colony in London, collected books for the institution. Early in the next century, Benjamin Silliman, acting on behalf of the College, bought books and instruments in England and arranged for the Library to receive many periodicals.

By 1941 a working library of some 30,000 books had developed. At that time a new building was planned by Dr. Harvey Cushing, officers of the School of Medicine, and University officials. Through an appropriation from the estate of John W. Sterling, Yale '64, the Library building became a reality.

The acquisition of many famous medical collections has made the Yale Medical Library one of the most inclusive in this country, with books and notable collections amounting to well over 100,000 volumes.

Dr. Morriss Heads TB Association

Dr. W. Haviland Morriss, Gaylord Farm Sanatorium, Wallingford, was re-elected president of the Connecticut Tuberculosis Association at its recent annual meeting. Dr. Cole B. Gibson, Meriden, and Miss Mary Geyer, Greenwich, were elected vice-presidents; Mrs. M. Gilbert Burford, Middletown, secretary; Henry F. Power, Norwich, treasurer; and Dr. Joseph I. Linde, New Haven, assistant treasurer.

Approximately 100 members of the association attended the meeting, held at the New Haven Country Club, Hamden, Thursday afternoon and evening, November 4.

In an illustrated talk at the dinner which concluded the meeting, Dr. John S. Barnwell, chief of the Tuberculosis Division, Veterans Administration, told association members that "the tuberculosis problem of the Veterans Administration is also a community problem." Directors of VA tuberculosis hospitals have experienced a marked increase in recent years of the number of veterans leaving the hospitals to spend Christmas holidays with relatives and friends, Dr. Barnwell pointed out. He asked the cooperation of association members in an educational program to explain the inherent danger of this practice to the health of veterans' families and urged that voluntary associations develop programs for observing Christmas at these hospitals. More than 300,000 veterans of World War II are now receiving compensation for tubercular disabilities, and this number is increasing at a rate of between 400 and 500 cases every month, Dr. Barnwell said.

Members of the association were welcomed by Dr. Leonard Parente, Hamden Health Officer, and Dr. Howard S. Colwell, president of the New Haven Tuberculosis and Health Association.

REPORT OF COMMITTEE ON PREPAID MEDICAL SERVICE

This Society began the consideration of a prepaid medical service plan nearly ten years ago. In 1939, through the agency of the Society, the Connecticut Legislature passed an Enabling Act for tax-free nonprofit medical service corporations. It may have been the first public statute of that kind enacted. At that time, probably less than half a dozen states had prepaid medical service plans in operation; now with the passage of time, there are less than half a dozen states that do not have either local or state-wide plans and Connecticut is one of them. The delay and lack of accomplishment in Connecticut can be analyzed and it depends upon a number of influences, among which are varying social and economic philosophies, indifference, and, of course, the disturbances caused by the war. Ours is the fifth or sixth committee to concern itself with this question and we hope that our efforts will be more fruitful than past experience.

This committee was authorized by the House of Delegates at its annual meeting on April 27, 1948 and consists of one member selected by each of the county medical associations and the President of the Society. We regret that the Tolland County Association has not appointed a representative on the committee. The committee was charged with carrying out the intent of a resolution, passed by the House of Delegates on the same day, to the effect that the House of Delegates approve a prepaid medical plan including service and indemnity features to be written by a nonprofit organization and that a majority of the directors of this nonprofit organization must be physicians.

The resolution appointing the committee states:

(6) "That when a plan has been devised, approved by the House of Delegates, and placed in operation, this committee shall continue as the Society's representatives in its operations . . ."

This committee has proceeded to follow the directions given it by the House of Delegates and now reports its activities.

At the beginning, it was learned that seven public minded citizens, not physicians, all but one of whom are directors of Connecticut Hospital Service, had, late in 1947 incorporated Connecticut Medical Service under the Enabling Act governing nonprofit medical service corporations and had deposited the five thousand dollars necessary to obtain such a charter. Negotiations were entered into with this group and a joint sub-committee consisting of three of the incorporators of Connecticut Medical Service and three members of the Committee on Prepaid Medical Service of the State Medical Society was created. This joint committee has worked with thorough and complete understanding and in the best of spirit. Early in its deliberations, the joint committee adopted a statement of general principles regarding the establishment of a voluntary prepayment medical service plan. Those principles were:

1. The Connecticut State Medical Society after long study has appointed a Planning Committee with authority to proceed with the development of plans to make available to the people of Connecticut, through a voluntary, nonprofit organization, a prepayment medical service plan of the combination service-indemnity type.

2. A group of seven laymen, including six Directors of Connecticut Hospital Service, Inc., have incorporated the Connecticut Medical Service, Inc. under Chapter 192-c of the 1939 Revision of the General Statutes of Connecticut. No further steps toward organization have as yet been undertaken.

3. The above action has been taken by both the medical and the lay group with the sole objective of serving the general public of Connecticut, and particularly that part falling in the lower income category.

4. It is considered desirable in the best public interest that a prepayment medical service plan be inaugurated through the Connecticut Medical Service, Inc., with the responsibility and authority for its operation shared properly by medical and lay interests, using the facilities of Connecticut Blue Cross as its administrative agent.

5. It is proposed that the organization of Connecticut Medical Service, Inc. be effected by the adoption of by-laws and the election of a board of directors properly representing the general public through equitably proportioned medical and lay persons. All directors, officers and committee members would serve without compensation.

6. It is recognized that final responsibility and authority for the operations of Connecticut Medical Service, Inc. must rest in one place, its Board of Directors.

7. It is accepted as a principle of operation that a committee composed of recognized medical practitioners be nominated by the Connnecticut State Medical Society and be appointed by the Board of Directors of Connecticut Medical Service, Inc. which will have authority and responsibility for advising in regard to all professional matters and adjusting differences or disputes involving medical practices under the Plan.

8. It is considered desirable and advantageous that Connecticut Medical Service, Inc. be closely allied with Connecticut Blue Cross; and that, as agent under an agreement stipulating proper, nonprofit compensation, Connecticut Blue Cross administer the sales, general public relations, accounting, routine claims, statistical and other administrative requirements of Connecticut Medical Service, Inc. other than those handled directly by Connecticut Medical Service, Inc.

9. It will be the purpose of Connecticut Medical Service, Inc. to facilitate through group prepayment methods and lowcost, nonprofit operation acceptable means to secure for the working population of Connecticut insurance against the cost of certain medical services. It will include all possible and insurable medical care which is commensurate with the ability of the large segment of low income people to pay for in premium form.

10. It is accepted that, as to those employed in the lower income levels, the program will provide full payment of the doctor's bill through the premium alone. As to those in the upper income levels, the program will provide a stipulated indemnity against charges which the individual doctor may

consider reasonable under the circumstances.

11. It is recognized that the inclusive income level defining the area within which the program will provide complete service coverage should be such as to cover at least one half of the working population and their families.

12. It is recognized that wide participation by low income people will be a major factor in considering the program's benefit to the general public and, likewies, to the medical profession.

13. It is recognized as an extremely important principle that, to thus benefit the general public, and the medical profession likewise, the scope of doctors' services must be practical and the schedule of fees for services must be reasonable, to a point which will permit a premium that a large proportion of the low income working population can and will pay.

14. It is recognized that, in order to operate, the program must have adequate assurance by most of Connecticut's doctors of medicine that they will participate and guarantee to accept as fees for service for the limited income group the amounts stipulated by contract.

15. It should be understood and agreed that, for an indefinite initial period, or until reasonable reserves are established, it may be necessary for the doctors to accept partial payments, with the balance, not obligatory, deferred. The participating doctors would thus help to underwrite the plan and share responsibility for avoidance of abuse.

16. It is recognized as paramount that the success of this program would depend very greatly upon complete understanding, cooperation and harmony at all times between the medical professional of Connecticut, the Connecticut Medical Service, Inc., and Connecticut Blue Cross. Their interests must always necessarily be one and identical—the general public interest, with equity for the three.

In arriving at the adoption of these principles, there evolved a joint statement of considerations which were:

(1) It is recognized that any prepayment medical service plan which will serve the public must not jeopardize the proper interests of the medical profession, either professionally or economically. Free choice of competent physicians must be maintained, and they must be reimbursed reasonably.

a. It is recognized that the rendering of medical services and the establishing of fees for service is strictly a prerogative of the medical profession alone. However, the method of financing payment of such fees as are established by the medical profession is not necessarily accomplished by the medical profession. Therefore, in the operation of a prepayment medical service plan, the establishing and policing of professional standards, the rendering of professional service and the establishing and operation of fees for medical service should be accomplished by the medical profession. Likewise, the method of financing such established fees includes many phases of administering a prepayment medical service plan other than those assigned to the medical profession, and might well be accomplished by laymen.

(2) It is recognized that any prepayment medical service plan which will serve the general public in the long run must not jeopardize in any way the hospitals, or Connecticut Blue Cross. The hospitals and Blue Cross belong to the general public and serve it through making financially available and providing necessary hospital care.

a. They also serve the interests of the medical profession. The hospital is obviously the doctors' workshop. Professionally, Blue Cross enables the doctor to hospitalize his patient when necessary, regardless of economic status. Economically, by payment of a major portion of the hospital bill, Blue Cross enables the patient to have something left to pay his doctor.

(3) The Connecticut medical profession could operate a prepayment medical service plan without anyone else's help. Its on-the-surface advantage to the medical profession of complete professional control would be of dubious value to the general public, its consumer.

(4) A prepayment plan providing indemnity against medical expense, rather than service, could be operated in all its phases by laymen, as is commercial insurance today. Without the medical profession's representation and control of the medical fees for its services, the advantages of such a plan to the general public would also be dubious.

(5) A prepayment medical plan could be operated without any reference whatsoever to Connecticut Blue Cross. However, such a plan would overlook the demand by many employers, as well as administrative logic, for a surgical plan which is "packaged" with Blue Cross for the purpose of general administration and savings to the general public. In addition, a plan administered without reference to Blue Cross might well prove to jeopardize the Blue Cross program, including its substantial benefit to hospitals and the medical profession. The advantages of such an independently operated plan to the public are likewise extremely dubious.

(6) Successful operation of any venture requires that authority be exactly commensurate with responsibility. The one group responsible, and held responsible by the public for the operation of a prepayment medical service plan, whether such group includes a mixture of professional and lay people or not, must have authority commensurate with that responsibility.

Proceeding with these principles and considerations always before us and with frequent references from the joint subcommittee to the entire committee of the State Medical Society and all of the incorporators of Connecticut Medical Service, we have evolved a prepayment plan for providing medical service for the people of Connecticut which we now present for your consideration. The documents comprising the framework of the Plan have been completed and the committee wishes to acknowledge here the invaluable assistance of Mr. Robert Parnall of Connecticut Hospital Service and Miss Mooney and Dr. Barker of the state office in perfecting the many details. These documents and proposals have been before the members of this House for more than two weeks and there has been ample opportunity for detailed study and discussion. Certain questions have inevitably arisen in your minds and we wish to anticipate some of those questions and give our reasons for the conclusions at which we have arrived.

1. SCHEDULE OF SURGICAL OPERATIONS

The most exacting attention was given to establishing the fees listed in the Schedule of Surgical Operations. It must be realized that it would be impossible, in Connecticut or

anywhere, to develop a schedule of this kind that would meet with unanimous approval. The committee is fully cognizant of the fact that some of the fees may be too low or too high and that these must be adjusted as experience is gained. This will be one of the immediate and major responsibilities of the Professional Policy Committee. We wish to point out, however, that the general level of the fees in our schedule is higher than that in any plan known to us except one, and we are reliably informed that that plan has never paid physicians more than 80 per cent of its published schedule.

2. INCLUDED BENEFITS

Long consideration was given to the benefits which should and could be included in the prepayment plan in the light of principles which were adopted. Also the fact was recognized that the premium must be such as to permit the sale of the Plan and that the premium would be determined by the benefits offered. Each benefit has been studied with care and those which are not in the contract have been omitted only after much deliberation.

(a) *Medical Care in the Hospital:*

The possibility of including at the outset payments per visit for medical care in the hospital was subjected to more intensive study and discussion than any other feature of the Plan. It was the opinion of some that such benefits must be provided in order to insure support of the Plan by general practitioners and through insuring their support to increase participation by surgeons, obstetricians and others. The discussion brought out, however, that according to the basic principles adopted, it was proposed to cover only insurable risks that could be paid for by the public in premium form and that medical care in the hospital does not yet appear to be insurable. Moreover, it has been estimated that the inclusion of all in-hospital medical care would raise the premium sufficiently to endanger the broad sale of the Plan. This might be especially the case where employers contemplated paying the entire premium cost for their employees and where they could obtain coverage which they considered adequate at a lower rate from commercial carriers. It was also pointed out that the physician in general practice and, for that matter, all physicians benefit by a prepayment plan because when the patient is covered for surgical operations and other necessarily expensive episodes of illness, there is money left over to pay for other medical care. It was agreed that the inclusion of medical benefits does not seem practical at the present time, that the subject should be kept under consideration and if experience with the Plan proves favorable, continued attention should be given to the liberalization of subscribers' benefits, perhaps to include medical care.

(b) *Anesthesiology:*

The administration of anesthesia by a physician is recognized as a professional service and would appropriately be considered the same as any other professional service, if it were not for a method of payment which has been developed between hospitals and anesthetists. In Connecticut, anesthetists are commonly employed by hospitals and charges for their services are rendered and collected by the hospital. Currently payment for these services is included under the "service benefits" allowed to subscribers by Connecticut Hospital Service and for purposes of accounting they have become "hospital services" rather than professional services. Revision of the Connecticut Hospital Service contract and adjustment of its premiums to effect the transfer of anesthesia from the hospital contract to the medical care contract would entail great expense and confusion. Even if this were accomplished, the success of the change would depend upon the universal acceptance on the part of anesthetists of the practice of rendering their own bill and being paid in the same manner as surgeons, obstetricians, and other medical attendants.

(c) *Radiology:*

The committee is aware of the desirability of treating radiology as a professional service as well as anesthesia, but the same obstacle to the inclusion of radiological services in a medical service contract exists under the customs firmly established in Connecticut hospitals. Although it may be that time, careful study, and some changes can bring radiology into the field of services to be covered by a medical plan, the committee is surely of the opinion that it would be unwise to delay the establishment of a Plan until this had been accomplished.

(d) *Pathology:*

The custom of paying for pathological and diagnostic laboratory procedures as a part of the hospital bill has become so fixed and accepted in the pattern of medical care in Connecticut that its inclusion in a medical service plan here is hardly to be considered.

(e) *Surgical Assistants:*

Provision was made originally to include in the Plan surgical assistants' fees of fifteen per cent of the surgeon's fee listed in the schedule of operations. This proposal was advocated at first, but mature consideration brought the conclusion that in the majority of instances, assistants at operations are members of the resident staffs in hospitals and it is not to be expected that they would be paid. In the few Connecticut hospitals where there are no resident staffs, if such a fifteen per cent additional fee were allowed, it is obvious that the fee for every operation would be raised by fifteen per cent which would in all probability raise the cost of the Plan to a level that might hinder its sale. In any case, the additional premium charge would be inequitable since all subscribers would have to pay the extra amount in order that the surgical assistant's fee could be met for the relatively few subscribers cared for in hospitals without resident staff assistance.

3. INCOME LIMITS

The committee's objective was the development of a Plan that would include all possible insurable medical care on a service basis commensurate with the ability of a large segment of the lower income group to pay for in premium form. Statistical inquiries were pursued which led to the conclusion that the annual income limits selected, i.e. individual, unmarried subscriber member $2,500; subscribing member and one financially dependent family member $3,000; and subscribing member and two or more dependent family members $3,500, would include in the service contract fifty to sixty per cent of the employed persons in the state. Physicians will be privileged to charge fees in addition to the indemnity schedule for persons above those limits. The provisions of this service feature in the contract shall not be binding upon the physician, unless the subscribing

member at the time of arrangement for care notifies the physician of his membership in the Plan and that he is within the income classification specified.

There are undoubtedly other questions and matters for discussion which should be brought before this meeting and your committee is most willing to consider them.

The Connecticut Hospital Service, which is involved in the development of an agency relationship to Connecticut Medical Service, has gone on record, through its Board of Directors, with a vote: "That the Corporation (Connecticut Hospital Service) approve and accept the joint statement of general principles regarding the establishment of a voluntary prepayment medical service plan accepted jointly by the incorporators of Connecticut Medical Service and the Committee on Prepaid Medical Service of the Connecticut State Medical Society with the understanding that this Corporation (Connecticut Hospital Service) act as agent for a program embodying such principles with the provision that a number of physicians, considered sufficiently large by this Board, agrees to act as participating physicians.

These documents and proposals as now presented to you have received the approval of your Committee on Prepaid Medical Service and constitute its recommendations to you. It is our opinion that the Committee has carried out in its best judgment the directive given to it by this House of Delegates in April with one exception. That exception is that the proposed By-Laws of Connecticut Medical Service do not provide for a majority of physician members on the Board of Directors of Connecticut Medical Service. We interpreted this part of the resolution to mean that the House of Delegates recognized that the rendering of medical services and the establishing of fees for these services are prerogatives of the medical profession alone. As the Committee proceeded with the development of the By-Laws, it was impressed that it was working in an atmosphere of confidence and good will with the representatives of Connecticut Hospital Service and that insistance on a majority of physician directors might imply misgiving on our part. It is the belief of your Committee that the Professional Policy Committee, which is to consist entirely of physicians named by the Council of the State Medical Society and which is to have complete control of professional policies and professional relationships, will give stronger medical influence to the activities of the Corporation than a majority of physicians on the Board of Directors would provide. Methods of financing the Plan and much of its administration are better managed by persons experienced in financial operations. We are indeed fortunate to have such a group of interested laymen willing to give the time necessary to guarantee the success of the business aspects of this project.

Finally, your Committee wishes to recommend three actions by this House:

1. The adoption of this report.

2. That this Society proceed without unnecessary delay to place in operation a plan to provide surgical and maternity services by prepayment, in administrative and promotional cooperation with Connecticut Hospital Service under a mutually satisfactory agreement, provided that a number of physicians, deemed adequate by the Council of the Connecticut State Medical Society to meet the professional obligations of the contract, agree to participate in the plan.

3. That paragraph six of the resolution passed by this House on April 27, 1948 creating this committee and which provided that, "When a plan has been devised, approved by the House of Delegates and placed in operation, this committee shall continue as the Society's representatives in its operation . . ." be rescinded and that the Council of this Society be directed, at the proper time, to designate six members of the Society to serve as directors of Connecticut Medical Service and to nominate the Professional Policy Committee of Connecticut Medical Service in compliance with the By-Laws of that corporation and provide such financing for the development of Connecticut Medical Service as may be indicated in the judgment of the Council.

PROPOSED VOLUNTARY PREPAID MEDICAL SERVICE PLAN

BY-LAWS OF CONNECTICUT MEDICAL SERVICE, INC.

Article I

Members

There shall be twelve Members of the Corporation of whom six shall be licensed physicians nominated by the Council of the Connecticut State Medical Society and six shall be laymen nominated by the Connecticut Hospital Service, Inc.

Upon the death or resignation of any Member of the Corporation, or upon receipt of written notice to the Corporation from either of the nominating bodies, to the effect that a Member nominated by such body is no longer approved, a vacancy shall be deemed to exist and shall be filled upon nomination of the Council of the Connecticut State Medical Society if such vacancy is that of a physician member, or of the Connecticut Hospital Service, Inc., if such vacancy is of a lay member.

Article II

Meetings of the Corporation

Section 1. The annual meeting of the members of the Corporation shall be held on the (third Tuesday of March in each year) for the election of Directors and the transaction of such other business as may properly come before the meeting. Voting by proxy shall be allowed.

Special meetings of the members of the Corporation may be called at any time by the President and shall be called at any time by the Secretary upon the request of any two members. All meetings shall be held at the office of the Corporation or at such other place as may be designated in the notice.

Section 2. *Notice of Meetings.* Notice of meetings of members of the Corporation, annual or special, shall specify the time and purpose of the meeting and shall be mailed to members at their respective addresses as on the Corporation's records, at least ten (10) days prior to such meeting.

Section 3. *Quorum.* At any meeting of the members of the Corporation a majority of members present in person or by proxy shall eonstitute a quorum for the transaetion of business.

Artiele III

Board of Directors

Seetion 1. The eontrol of the business and the affairs of the Corporation shall be in a Board of Direetors whieh shall eonsist of the members of the Corporation.

Seetion 2. *Powers and Duties of the Directors.* The Board of Direetors shall have the general management of the affairs, property and business of the Corporation, and, subjeet to these By-Laws, may adopt such rules and regulations for that purpose and for the conduct of its meetings as the Board may deem proper. It shall appoint an Exeeutive Committee, and may appoint sueh other committees as from time to time it shall deem advisable.

Article IV

Meetings of Directors

Section 1. The annual meeting of the Board of Direetors shall be held immediately following the annual meeting of the Corporation for the purpose of eleeting officers, appointing committees and for the transaction of sueh other business as may properly eome before the meeting.

Seetion 2. *Meetings.* Meetings of the Board of Direetors may, unless otherwise preseribed by law, be called at any time by the President or the Secretary. On the written request of any two Direetors, the Seeretary shall call a meeting of the Board. Meetings shall be held at the offiee of the Corporation, or at sueh other plaee as may from time to time be designated by resolution of the Board of Direetors.

Seetion 3. *Notice of Meetings.* Unless otherwise preseribed by law, notiee of the time, plaee and purpose of any meeting of the Board of Direetors shall be given by mailing same to the Direetors at their respective post offiee addresses as on the Corporation's reeords not later than five (5) days prior to such meeting.

Seetion 4. *Quorum.* At all meetings of the Board of Direetors a majority of the Directors shall constitute a quorum for the transaetion of business. Any aet of a majority of the Board of Direetors eonstituting a quorum present at a duly ealled meeting shall be the aet of the Board of Directors.

Article V

Executive Committee

Section 1. The Executive Committee shall consist of five (5) members of the Board of Directors, of which the President shall be a member by virtue of his office, and at least two members of which shall be physicians; those members other than the President shall be nominated by the President and eleeted by the Direetors.

Seetion 2. *Meetings.* Meetings of the Exeeutive Committee may be called at any time by the President or the Secretary of the Board of Directors. Such meetings will be held at the office of the Corporation, or at such other place as may from time to time be designated by resolution of the Executive Committee. Notice of the time, place and purpose of meetings of the Executive Committee shall be given by mailing same to its members not later than three (3) days prior to the meeting.

Seetion 3. *Quorum.* At all meetings of the Executive Committee a majority of the members of the Executive Committee shall constitute a quorum for the transaction of business. Any aet of a majority of the Exeeutive Committee constituting a quorum present at a duly ealled meeting shall be the aet of the Exeeutive Committee.

Seetion 4. *Powers and Duties.* The Exeeutive Committee shall have full power to aet for the Board of Direetors during intervals between meetings of the Board. It shall earry out all orders issued by the Board of Directors and shall report to the Board all actions taken.

Artiele VI

Officers

Section 1. The Corporation shall have as officers a President, a Viee-President, a Secretary and a Treasurer, all of whom shall be chosen by the Directors annually at the close of the annual meeting of the Board of Direetors. Eaeh offieer shall hold offiee until the next annual meeting of the Board of Direetors, or until his suecessor shall have been duly elected and qualified. All offieers shall be chosen from among the members of the Board of Directors. Any vacancy in any of the above offiees shall be filled for the unexpired portion of the term by the Board of Direetors at any regular meeting, or any speeial meeting called for sueh purpose. The Corporation may also have such other offieers or agents as the Board of Direetors may deem necessary, who will hold office for sueh term as the Board of Direetors may fix, and who shall have such authority and perform such duties as the Board of Direetors may preseribe. The performanee of any duty of any offieer described hereafter may be properly delegated by him to another person or persons with the approval of the Board of Directors.

Seetion 2. *President.* The President shall be the chief offieer of the Corporation. It shall be his duty to preside at all meetings of the members of the Corporation and of the Board of Directors and of the Executive Committee. He shall, subjeet to the approval of the Board of Directors, perform all duties incidental to his office.

Seetion 3. *Vice-President.* In the absence or inability to aet of the President, or if the offiee of President be vaeant, the Vice-President may exereise all the powers of the President. The Viee-President shall have sueh power and perform such other duties as may be assigned to him or authorized by order of the Board of Direetors.

Seetion 4. *Treasurer.* The Treasurer shall have general supervision over the care and custody of the funds and securities of the Corporation and shall deposit the same or cause the same to be deposited in the name of the Corporation in sueh bank or banks, trust eompany or trust companies, and in such safe deposit company or safe deposit eompanies, as the Board of Direetors may designate. He shall keep or cause to be kept full and accurate accounts of all receipts and disbursements of the Corporation, and whenever required by the Board of Directors he shall render or cause to be rendered financial statements of the Corporation. He shall prepare and execute with the President and file any annual report or reports, statement or statements, which may be required by law.

Section 5. *Secretary.* The Secretary shall keep or cause to be kept the minutes, and act as Secretary of all meetings of the Corporation, the Board of Directors and the Executive Committee. He shall be responsible for the giving and serving of all notices of meetings of the Corporation, the Board of Directors and the Executive Committee. He shall be custodian of the corporate records and of the corporate seal, he shall perform all duties usually incident to the office of Secretary and such other duties as may be assigned to him by the Board of Directors.

Section 6. *Compensation of Officers.* No officer or Director of the Corporation shall receive directly or indirectly any salary, compensation or emolument from the Corporation as such officer or in any other capacity.

Section 7. *Bonds.* The Board of Directors shall have power to require any officer or employee of the Corporation to give bonds for the faithful discharge of his duties in such form and with such surety or sureties as the Board of Directors may deem advisable.

Article VII

Professional Policy Committee

The Board of Directors shall, at its annual meeting, appoint a professional policy committee of nine members and designate its chairman. The committee shall consist of four physician members of the Board of Directors and five physicians selected from nominations made by the Council of the Connecticut State Medical Society. Each member of the professional policy committee so appointed shall hold office for a term of one year from the date of the annual meeting of the Board of Directors, or until his successor has been appointed by the Board of Directors.

Section 1. *Powers and Duties.* The Board of Directors shall empower the professional policy committee to determine the following matters, subject, however, to the right of the Board of Directors to exercise final authority in all such matters:

a. All questions involving medical ethics or professional practice.

b. All disciplinary action involving physicians.

c. Matters arising out of the subscription agreement or the agreement with participating physicians involving: the amount, type, or manner of rendering professional service; changes in the fee schedule for such services; standards of medical care; or the professional qualifications of any physician or group of physicians.

d. Prior review of written or oral representations which the Corporation or its officers shall propose making to subscribers or the public which concern professional or medical matters.

e. The interpretation of the Corporation's policies, practices, and operations to participating physicians, to the Connecticut State Medical Society and to its component county associations.

f. The maintenance of a cordial and effective liaison between the Corporation and participating physicians, the Connecticut State Medical Society and its component county associations.

Section 2. The Professional Policy Committee shall recommend to the Executive Committee for employment a Director of Medical Services.

Section 3. *Meetings.* The meetings of the professional policy committee shall be held at such times and places, and in such a manner, as designated by the chairman of the professional policy committee.

Article VIII

Participating Physicians

A participating physician shall be any doctor of medicine licensed to practice medicine in the State of Connecticut pursuant to the provisions of Section 2747 of the Cumulative Statutes of Connecticut and who agrees in writing with, and in a form approved by, the Corporation to perform the medical and surgical services specified in the Subscribers' Contracts that may be issued by the Corporation, at such rate of compensation as shall be determined by the Board of Directors and who agrees to abide by the Rules and Regulations of the Corporation applicable to participating physicians.

Article IX

General Manager

The Executive Committee shall employ a General Manager who shall have general charge and management of the business of the Corporation subject to its direction. He shall receive such compensation as may be fixed by the Executive Committee.

Article X

Director of Medical Services

The Executive Committee shall, on recommendation of the Professional Policy Committee, employ a Director of Medical Services who shall have general charge of the medical and professional operations and relationships of the Corporation under direction of the Professional Policy Committee as outlined in Article VII, Section 1 of these By-Laws.

Article XI

Negotiable Instruments

All checks, drafts, bills of exchange, notes or other obligations or orders for the payment of money shall be signed in the name of the Corporation by such officer or officers, person or persons as the Executive Committee of the Corporation may from time to time designate by resolution.

Article XII

Funds

The surplus funds of this Corporation shall be invested only in securities provided by the law of this state governing medical service corporations, and such funds shall be in the custody or control of such proper bank or banks, or trust company or trust companies, as the Executive Committee may determine.

Article XIII

Amendments

These By-Laws may be amended at any duly called meeting of the Corporation by a majority vote of the members of the Corporation constituting a quorum present, provided notice of said proposed amendment to be considered and acted upon is inserted in the notice of such meeting.

CONNECTICUT MEDICAL SERVICE, INC. MEMBERSHIP REGULATIONS

I. CONSIDERATION

1. In consideration of concurrent Membership in Connecticut Hospital Service, Inc. and in consideration of and upon payment of the membership charges as specified in the REGULATIONS, the Connecticut Medical Service, Inc. hereby agrees to furnish to Members the benefits of said Connecticut Medical Service, Inc. in accordance with the terms and conditions of these REGULATIONS.

II. CORPORATION

1. The term "Corporation" as used hereinafter shall include the Connecticut Medical Service, Inc. and any successor corporation.

III. MEMBER

1. A Subscribing Member shall be any person to whom a Membership Certificate has been issued and made effective by this Corporation.

2. A Family Member shall be the Subscribing Member's spouse or unmarried dependent child, aged not less than one month nor more than nineteen (19) years, who has been listed on the Subscribing Member's subscription application which has been accepted and made effective by this Corporation. (See Section XI, paragraph 7 herein.)

3. The term "Member" as used herein shall mean either the Subscribing Member or a Family Member.

4. A person shall cease to be a Member upon termination of this contract, or as provided in Section XI, paragraph 7 herein.

IV. PARTICIPATING PHYSICIAN

1. The term "Participating Physician" as used herein shall mean any legally licensed doctor of medicine with whom this Corporation has entered into an agreement to render, to any Member whom he accepts for treatment, the services provided in this contract subject to its terms and conditions.

V. CONTRACT AND EFFECTIVE DATE

1. The entire contract between the Member and the Corporation consists of the Certificate of Membership, the REGULATIONS, including all amendments thereto and all endorsements thereon and attached papers, if any. No statement by the Subscribing Member in his subscription application shall void the contract or be used in any legal proceedings thereunder unless such application, or an exact copy thereof, is included in, or attached to, the Certificate of Membership.

2. The effective date of the contract shall be the effective date of the Certificate of Membership issued to the Subscribing Member.

3. The contract continues until terminated or changed as hereinafter provided.

VI. BENEFITS

1. *General.*

a. Upon receipt of due proof satisfactory to Connecticut Medical Service, Inc. that the Member has undergone an operation which is specified in the Schedule of Surgical Operations included herein because of injury, disease or pregnancy, and which is performed by a doctor of medicine legally licensed to practice medicine.

Connecticut Medical Service, Inc. shall, subject to the terms and limitations of this contract, provide benefit in the amount of the actual surgical fee charged to the Member for such surgical operation, on the condition, however, that in no case shall the amount of such benefit exceed the amount specified for such operation in the Schedule of Operations contained herein.

b. If two or more of the surgical operations specified in the Schedule of Surgical Operations included herein are performed upon the Member at any one time, payment will be made only for the operation for which the largest amount is allowed in the Schedule of Surgical Operations; or, if said operations are performed during any one continuous period of disability within any calendar year, whether from one or more causes, or during successive periods of disability due to the same or related cause or causes, the total amount of reimbursement under this contract for all such operations performed shall not exceed $250.

c. Maternity benefits and benefits for conditions resulting from pregnancy listed in the Schedule of Surgical Operations will be available only after both the Member and her husband have held continuous membership in this Corporation for a minimum period of one year.

2. *Service Benefits.*

a. The Participating Physicians of this Corporation agree to accept as full payment the amount listed in the Schedule of Surgical Operations (Section XIII) for services rendered under this contract to Subscribing Members and to their Financially Dependent enrolled Family Members PROVIDED THAT the annual income of the Subscribing Member, as related to Plan I, Plan II, or Plan III type of Membership, does not exceed the limits described below:

Plan I. Subscribing Member, individual, unmarried: $2,500.

Plan II. Subscribing Member who has enrolled one Family Member: $3,000.

Plan III. Subscribing Member who has enrolled two or more Family Members: $3,500.

b. The provisions of this Section VI, paragraph 2, with respect to the fee of the Participating Physician shall not be binding upon the physician unless the Subscribing Member, at the time of arrangement for care, notifies the physician of his membership in this Corporation and that he is within the income classifications specified in parargraph (a) above.

c. To the extent that a Member is actually indemnified for surgical expenses resulting from accident or negligent injury, the provisions of this Section (VI. 2) shall not be binding upon the physician.

3. *Indemnity Benefits*

a. In the event, at the time service is rendered, the annual income of the Subscribing Member shall exceed the applicable limits set forth in Section VI, paragraph 2 herein, the amount of indemnity, subject to the limitations set forth in Section VI, paragraph 1, shall be applied as a credit by the Participating Physician towards his fee for such care rendered. The Member shall be responsible for the difference, if any, between such fee and the amount of such indemnity

directly to the Participating Physician without recourse to Connecticut Medical Service, Inc.

b. When care is rendered by any legally licensed doctor of medicine other than a Participating Physician, indemnity, subject to the limitations set forth in Section VI, paragraph 1, will be paid for such care irrespective of the income level of the Subscribing Member.

VII. OTHER PROVISIONS

Notice of Claims.

1. Written notice of claim for benefits in a form satisfactory to this Corporation, by or on behalf of the Member, must be given to the Corporation within thirty (30) days following the date of the surgical or obstetrical procedure for which benefits are claimed. The notice must give particulars sufficient to identify the Member, and must be certified by the physician as to the service rendered. Failure to give notice within the time provided by this Agreement shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice, and that notice was given as soon as was reasonably possible.

2. All benefits provided in this Agreement will be furnished immediately after receipt of due proof.

3. For all benefits provided in this Agreement the Corporation shall make payment to the Participating Physician direct unless the physician certifies that his fee has been paid, then payment shall be made to the Subscribing Member subject to the terms and limitations of this contract. When care provided under this Agreement is furnished by any other legally licensed doctor of medicine, this Corporation reserves the right to pay either the Subscribing Member or such doctor of medicine, as this Corporation may elect.

4. No action at law or in equity shall be brought to recover on this agreement prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the requirements of this agreement, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of claim is required by the Agreement.

Extent of Liability.

5. This Corporation does not engage in the practice of medicine nor does it undertake to provide a physician for the Member. Further, it is not responsible for any physician's professional acts, omissions or conduct and shall be under no liability in connection with care rendered or service by any physician.

6. This Corporation is liable only to provide Surgical and Maternity Expense Indemnity to the extent, and under the conditions, set forth in this contract.

VIII. BENEFITS NOT PROVIDED

1. This Agreement does not apply:

a. With respect to any items not specifically enumerated in this Agreement.

b. With respect to a surgical operation which is obtained: under a Workmen's Compensation Act; in a Veteran's, or other Federal Hospital; or which, by law, was rendered without expense to the Member.

c. With respect to maternity benefits and benefits for conditions resulting from pregnancy listed in the Schedule of Surgical Operations until both the Member and her husband have held continuous membership in this Corporation for a minimum period of one year (See Section VI, paragraph 1-c).

IX. WAIVER OF PHYSICAL EXAMINATION

This Corporation hereby waives a physical examination as a provision of Membership. In consideration of such waiver, the Member agrees that, during the pendency of any claims hereunder, this Corporation shall have the right and opportunity to have the person of the Member examined by such physicians and surgeon as it may designate, when and as often as it may reasonably require; and the Member agrees to furnish, and authorizes any hospital, physician or surgeon to furnish, this Corporation such information as it may require; said information to be treated as confidential.

X. MEMBERSHIP CHARGES

1. The current amount of membership charges shall be as follows:

a. For Subscribing Members remitting to this Corporation as a payroll group through their employer:

	Monthly
Subscribing Member	$ .75
Subscribing Member and enrolled spouse	1.50
Subscribing Member and enrolled family	2.25

b. For Subscribing Members remitting to this Corporation individually and direct:

	Quarterly
Subscribing Member	$2.75
Subscribing Member and enrolled spouse	5.50
Subscribing Member and enrolled family	8.25

2. Membership charges will be paid to the Corporation in advance.

3. Connecticut Medical Service, Inc. has designated Connecticut Hospital Service, Inc. as its sole agent to receive payment of charges under this contract. It is a condition of this contract that payment to Connecticut Hospital Service, Inc., as agent for Connecticut Medical Service, Inc., of charges under this contract shall be made concurrently with charges due by the subscriber to Connecticut Hospital Service, Inc., under its contract for hospital service.

XI. PROVISION FOR TERMINATION OR AMENDMENT

1. On the effective date of termination of this agreement for any cause membership shall cease and this corporation shall have no liability whatsoever for any operation performed thereafter, except as provided in Section XI, paragraph 6 herein.

2. This Agreement shall automatically terminate on the same date the Member of Connecticut Medical Service, Inc. ceases to be a Member of Connecticut Hospital Service, Inc.

3. This agreement shall automatically terminate if the Subscribing Member fails to make payment within fifteen (15) days after the same becomes due and payable according to the REGULATIONS.

4. This agreement may be terminated by the Subscribing Member by giving thirty (30) days prior written notice mailed to this Corporation at its principal office at New Haven, Connecticut.

5. This Corporation reserves the right to amend any provision of this agreement or to terminate same, and to determine the amount of the membership charges as it deems necessary, by giving at least thirty (30) days prior written notice either by notice mailed to the Subscribing Member's address as it appears on the records of this Corporation, or delivered to the Subscribing Member's employer or group remitting agent, or published in the daily newspapers published in the State of Connecticut as this Corporation shall elect. If there is no default in the Subscribing Member's payment of membership charges after such notice of a change in benefits or charges has been given the Subscribing Member, it is understood that such change is accepted by the Subscribing Member.

6. If this Corporation terminates or amends this agreement at a time when the member is in a pregnant condition, if entitled to maternity benefits under this agreement, this Corporation agrees to furnish such person the maternity benefits as stated herein for a period of ten months next following the date of notice of such termination or amendment.

7. This agreement shall automatically terminate as to an enrolled child Member on the Membership payment due date next following such child's marriage or attainment of age nineteen (19), but in no event more than ninety (90) days following such marriage or attainment of age nineteen (19).

8. In the event that this Corporation or the Subscribing Member shall elect to terminate this Agreement, this Corporation shall refund to the Subscribing Member any subscription fees paid beyond the effective date of termination, and such refund shall constitute a full and final performance of all obligations of this Corporation under such agreement.

XII. BENEFITS NON-ASSIGNABLE

1. The benefits of this Agreement are personal to the Member and are in no way assignable.

XIII. SCHEDULE OF SURGICAL OPERATIONS

Maximum Reimbursement for Operative Procedures and Usual After-Care up to Three Weeks

INFECTIONS AND TRAUMATA

Third degree burns
Skin grafts
Pinch grafts
} Individual consideration at the discretion of the Corporation

Deep abscesses—incision and drainage—Individual consideration at the discretion of the Corporation

Repair of recent large wounds in hospital
Extensive lacerations—debridement
Individual consideration at the discretion of the Corporation

Carbuncle—excision	$ 25.00
Tendon of hand—drainage	25.00
Tendon sheath and compartments	25.00
Foreign body removal	
Under deep structures, requiring open operation to remove	15.00
Ulcer—excision	10.00

CYSTS

Aspiration	$ 5.00
Branchial cleft cyst—removal	150.00
Complicated cyst—Individual consideration at the discretion of the Corporation	
Pilonidal cyst or sinus—complete excision	75.00
Sebaceous cysts—removal	
Small	5.00
Large	8.00
Thyroglossal cyst with removal of mid-portion of hyoid bone	150.00

TUMORS—EXTERNAL OR SUPERFICIAL

Individual consideration at the discretion of the Corporation

BIOPSY

Biopsy of deep structures	$ 25.00
Superficial biopsy	5.00

LYMPH NODES

Superficial lymph nodes—removal (neck or groin)	$ 10.00

THYROID

Adenoma—enucleation of	$125.00
Thyroidectomy	150.00

BREAST

Tumor—biopsy or enucleation of small tumor	$ 25.00
Radical removal	165.00
Simple removal	85.00

MISCELLANEOUS

Saphenous vein ligation w/ dissection of bulb	
Unilateral	$ 50.00
Bilateral	75.00
Varicose veins w/dissection of bulb and stipping or multiple ligations	
Unilateral	75.00
Bilateral	100.00
Toenail, ingrown—removal of	15.00

THORACIC PROCEDURES

Bronchoscopy—diagnostic, including biopsy	$ 35,00
Bronchoscopy—operative	50.00
Empyema—rib resection	50.00
Phrenic nerve—crushing	25.00
Pleura—paracentesis	7.00
Pneumothorax, artificial—first	15.00
Refills (each)	7.00
Thoracoplasty—first stage	150.00
Each additional stage	50.00
Thoracoscopy—cutting pleural adhesions	50.00
Thoracoscopy—diagnostic	25.00
Thoracotomy—surgical exploratory	125.00
Lobectomy	175.00
Lung abscess—first stage	100.00
Lung abscess—second stage	50.00
Lung abscess—third stage	50 00
Pneumonectomy	200.00

ABDOMINAL PROCEDURES

Abdominal paracentesis	$ 10.00
Abdominal peritoneoscopy	25.00
Appendectomy	100.00
Appendiceal abscess, drainage	75.00
Cholecystectomy	150.00
Cholecystostomy	125.00
Colon resection	200.00
Colostomy	125.00
Diverticulum, intestinal	125.00
Esophagoscopy—diagnostic	35.00
Esophagoscopy—operative	50.00
Esophagus—dilatation	25.00
Gastrectomy	200.00
Gastro-enterostomy	150.00
Gastrostomy—temporary	50.00
Gastrostomy—permanent	125.00
Gastrotomy	125.00
Hernia—femoral, single	100.00
Hernia—femoral, bilateral	125.00
Herniotomy—inguinal, single	100.00
Herniotomy—inguinal, bilateral	125.00
Herniotomy—ventral	100.00
Intestinal anastomosis	150.00
Intestinal resection	200.00
Laparotomy—exploratory, for diagnosis or biopsy	100.00
Splenectomy	175.00
Ulcer—duodenal, excision of	150.00
Ulcer—perforated, closure of	125.00
Recurrent hernia, including those w/fascial transplants	135.00
Common duct resection and reconstruction	200.00

PROCTOLOGY

Fissurectomy	$ 25.00
Fistulectomy—single	50.00
Fistulectomy—complicated horseshoe fistula	75.00
Hemorrhoidectomy—external	10.00
Hemorrhoidectomy—external or internal	65.00
Incision—thrombotic hemorrhoid, papilla skin tags	10.00
Pectenotomy	25.00
Polypectomy (excis. and fulguration)	35.00
Proctoscopy	5.00
Prolapsed rectum—repair of	150.00
Rectum—radical resection or amputation for malignancy	200.00
Sigmoidoscopy—surgical	10.00
Sphincter, dilatation	5.00

UROLOGY

Bladder tumor—fulguration	$ 50.00
Circumcision	
Adult	25.00
Children to 15 years	12.00
New born	5.00
Cystoscopy (bladder only), diagnostic	12.00
Cystocopy with catheterization of ureters	25.00
Cystotomy or cystostomy	50.00
Epididymectomy—(including plastics)	
Unilateral	75.00
Bilateral	100.00
Hydrocele—radical operation	50.00
Nephrectomy	175.00
Nephropexy	175.00
Nephrotomy	175.00
Orchidectomy	50.00
Orchidectomy—w/dissection of inguinal glands	
Unilateral	150.00
Bilateral	200.00
Phimosis—dorsal slit	10.00
Prostatectomy	
Simple punch for median bar	50.00
Partial resection—via scope	100.00
Complete resection—any approach	150.00
Prostatic abscess	50.00
Renal lavage	10.00
Tunica vaginalis, paracentesis	5.00
Ureteral stone removed—via scope	75.00
Ureterotomy	150.00
Urethroscopy	
For local medication	10.00
For fulguration or incision	15.00
Varicocele operation	50.00
Vasectomy—bilateral	25.00
Urethral dilatation	5.00
Orchidopexy	100.00
Orchidopexy with second stage "Toric"	125.00
Hypospadias	
Perineal	125.00
Each additional stage	50.00
Maximum	200.00
Hypospadias	
Scrotal	75.00
Each additional stage	25.00
Maximum	175.00
Bladder resection—segmental	175.00
Bladder resection—ureteral transplants	200.00

OBSTETRICS AND GYNECOLOGY

Abortion or miscarriage (if hospitalized and curetted)	$ 35.00
Atresia of vagina—correction by dilatation	10.00
Cesarean section (without prenatal care)	100.00
Cervical polyp—excision or fulguration	25.00
Cervix	
Amputation	50.00
Dilitation of	10.00
Repair of tear	20.00
Conization	15.00
Cul-de-sac, drainage	10.00
Curettage—diagnostic or therapeutic	25.00
Cystocele repair	100.00
Fistula, recto-vaginal	100.00
Fistula, vesico-vaginal	100.00
Hysterectomy	
(Radical for cancer)	200.00
Simple, non-malignant	135.00
W/salpingo-oophorectomy	150.00
Labial tumors and cysts, removal	25.00
Myomectomy, with laparotomy	100.00
Oophorectomy (one or two)	100.00
Perineorrhaphy—for cystocele and rectocele	150.00
Pregnancy—delivery and postnatal care	60.00
Pregnancy—ectopic, ruptured	125.00

Rectocele repair	100.00
Salpingectomy (one or two)	100.00
Salpingo-oophorectomy	100.00
Trachelorrhaphy	50.00
Urethral caruncle, removal	20.00
Uterus, suspension of	100.00
Uterine polypi, removal	35.00
Vaginal plastic—including cystocele and rectocele	150.00

OPHTHALMOLOGY

Canthotomy	$ 7.00
Cataract, removal	125.00
Chalazion—excision	10.00
Chalazion—incision	5.00
Conjuctiva	
Suture, 1 to 3 sutures	15.00
Extensive suturing	25.00
Flap for corneal ulcer, etc.	25.00
Cornea—paracentesis	12.00
Corneal ulcer—cautery	8.00
Corneal ulcer—deliminating keratotomy	50.00
Entropion or ectropion, plastic op.	62.00
Entropion or ectropion, Ziegler's puncture	38.00
Enucleation of eye	100.00
Enucleation and implantation	125.00
Evisceration of eye, or simple enucleation	75.00
Foreign body, interior of eye, removal	100.00
Foreign body—removal from cornea	5.00
Glaucoma, filtrating operation	125.00
Iridectomy	62.00
Lachrymal duct stenosis, probing	8.00
Lachrymal sac—removal	62.00
Pterygium	38.00
Ptosis—correction of	125.00
Retinal detachment (multiple fusions)	175.00
Tenotomy	50.00
Strabismus	
Unilateral	100.00
Bilateral	150.00
Additional surgery	50.00
Maximum any one case	200.00
Symblepharon, release	37.00
Tarsorrhaphy—orbicularis paralysis	38.00
Tumor—exenteration of orbit	125.00
Needling cataract	37.00
Dacro-cysto-rhinostomy	100.00

EAR, NOSE AND THROAT

Mastoidectomy	
Acute	$125.00
Bilateral	200.00
Radical	175.00
Paracentesis tympani	8.00
Larynx—removal of cord tumor	75.00
Antrum	
Caldwell-Luc, unilateral	100.00
Caldwell-Luc, bilateral	150.00
Puncture	5.00
Ethmo-sphenoidectomy	50.00
Laryngectomy	200.00
Larynx—intubation	25.00
Nasal polypi—removal	15.00
Each repeat	5.00
Maximum	35.00
Nasal-antral window	37.00
Nasal-antral window bilateral	50.00
Submucous resection	75.00
Tonsillectomy and adenoidectomy	
Under 15 years	25.00
Over 15 years	40.00
Tracheotomy	50.00
Turbinectomy	15.00
Uvulectomy	5.00
Adenoidectomy	25.00
External ethmo-frontal (uni—or bilateral)	150.00
Electro-coagulation	10.00
Epistaxis	8.00

NEUROLOGY

Chordotomy	
Bilateral	$150.00
Unilateral	150.00
Craniotomy for tumor, abscess, depressed fracture	200.00
Decompression—subtemporal	125.00
Encephalogram—introduction of material	25.00
Laminectomy—cord tumor or nucleus pulposus	150.00
Lumbar puncture	5.00
Section of 5th nerve—tri-geminal neuralgia	150.00
Section of 8th nerve—Meniere's Syndrome	150.00
Skull defect—plastic	150.00
Splanchnicotomy	
Peet	150.00
Smithwick	200.00
Trephine—subdural hematoma	75.00
Ventriculogram—introduction of material (x-ray not included)	50.00
Nerve block	10.00

ORTHOPEDICS

Fractures

The following fees apply to uncomplicated fractures managed by closed reduction

Cost of medium, casts, braces and other appliances is not included and should be provided at the expense of the patient

Acetabulum	$ 65.00
Carpal	35.00
Clavicle	40.00
Colles fracture (wrist)	50.00
Femur	100.00
Forearm—one bone	50.00
Forearm—both bones	65.00
Humerus	65.00
Ilium	62.00
Fibula	50.00
Tibia	75.00
Tibia and fibula	100.00
Mandible	38.00
Maxilla or zygoma	25.00
Metacarpals	35.00
Metatarsal	35.00
Nasal bones	25.00
Olecranon	40.00

Os calcis	40.00
Patella	50.00
Pelvis	75.00
Phalanx of finger	20.00
Phalanx of toe	10.00
Phalanx, each additional	5.00
Potts-Trimalleolor fracture (ankle)	100.00
Sacrum	25.00
Scapula	50.00
Tarsal	25.00

Compound fractures, add 50 per cent to the fee for simple fracture.

Open reduction with internal fixation, for bone plating or bone splinting or inlay, two times fee for simple fracture

Skeletal traction, including use of tongs, wires, pins, add 50 per cent to fee for simple fracture

Bone graft of non-united fracture three times the fee for simple fracture, but not to exceed $150

Bone drilling for delayed union or non-united fracture, same fee as for treating original fracture

Open operation for removing splinters of bone from open wound, simple sequestrum, plate, screws or internal splint material, 50 per cent of fee for treating simple fracture

Reduction of vicious union by use of Thomas wrench, add 50 per cent of fee for simple fracture

DISLOCATIONS

Dislocations—manipulative reductions not requiring anesthetic or assistance	$ 10.00
Dislocations—major reductions under anesthesia	25.00

JOINTS

Acromio-clavicular separation, repair of	$125.00
Arthrodesis—shoulder, elbow, sacro-iliac, hip, knee	175.00
Arthroplasty—shoulder, elbow, hip, knee	175.00
Arthrodesis—wrist, ankle, foot	100.00
Arthrotomy—large (shoulder, hip, knee)	75.00
Arthrotomy—small (ankle, wrist)	50.00
Cartilage, semi-lunar—removal of detached	100.00
Disarticulation at hip or shoulder joint	150.00
Ligaments, knee—repair of crucial	150.00
Ligaments, knee—repair of lateral	100.00
Patella—repair of recurrent dislocation	100.00
Spinal fusion	150.00
Spinal fusion with bone graft	200..00
Amputations	
Finger or toe	20.00
Finger or toe, each additional	5.00
Foot, leg, ankle	75.00
Hand, wrist, forearm, arm	75.00
Knee, thigh	100.00
Hip	150.00
Astragalectomy	100.00
Bunion operation, plastic, one foot	50.00
Bunion operation, both feet	75.00
Bochler method (os calcis fracture w/cast)	125.00
Bursa	
Excision of—large	50.00
Excision of—small	30.00
Novocaine injection	10.00
Repair of wounds or removal of foreign bodies—50 per cent of fee for excision	
Fasciotomy—Ober's	75.00
Ganglion—removal of	37.00
Laminectomy for tumor	200.00
Laminectomy for disc	200.00
Lavage—of shoulder joint for calcified bursa	25.00
Osteomyelitis—acute, small incision for bone drainage	25.00
Osteomyelitis—acute, large incision for bone drainage	50.00
Osteomyelitis—sequestrectomy—small	50.00
Osteomyelitis—sequestrectomy—large	100.00
Removal of metartarsal heads	25.00
Removal of carpal bone	38.00
Removal of spinous process	37.00
Removal of spurs and exostosis	38.00
Smith-Peterson operation (sacro-iliac)	150.00
Tendon surgery	
Lengthening	65.00
Sutures, each tendon (not to exceed $200)	37.00
Tenotomy (subcutaneous) (two or more, add 50 per cent)	30.00
Transplants	75.00
Transplants, each additional (maximum $150)	38.00
Traction skeletal, when not part of fracture fee otherwise charged	12.00

CUTTING OPERATIONS NOT LISTED

Maximum benefits, if any, as determined by Connecticut Medical Service, Inc.

XIV. APPROVED BY INSURANCE COMMISSIONER

The REGULATIONS, Subscription Application and Certificate of Membership have been approved by the Insurance Commissioner of the State of Connecticut and copies thereof are on file in his office located at Hartford, Conn.

AGREEMENT BETWEEN PARTICIPATING PHYSICIAN AND CONNECTICUT MEDICAL SERVICE, INC.

Effective Date.....

This Agreement is made this..... day of ..... 194..... between Connecticut Medical Service, Inc., hereinafter called the Corporation, organized pursuant to Chapter 192c Cumulative Statutes of the State of Connecticut, and ....., a doctor of medicine, hereinafter called the Participating Physician, holding a license to practice medicine in the State of Connecticut, pursuant to the statute laws of the State of Connecticut.

I. In consideration of the benefits accruing to him, the Participating Physician agrees to furnish professional services to the Members of Connecticut Medical Service, Inc. who are accepted by him for treatment, in accordance with the terms and limitations of the contract between Connecticut Medical Service, Inc. and its subscribers, and any or all amendments thereto. The Participating Physician agrees to comply with all the provisions of the Corporation's By-Laws and all the amendments thereto. The subscriber's contract

and the By-Laws are annexed hereto and made part of this Agreement.

II. The Participating Physician agrees to submit to the Corporation complete information of services rendered to Members as required by the Corporation, on a form provided by the Corporation; this claim shall be submitted within thirty (30) days of the completion of the surgical operation. Failure to submit a claim on the form provided by the Corporation within the prescribed thirty (30) days shall result in a penalty charge of 10 per cent of the payment to the Physician for each month such account is not submitted for payment. In the event such penalty charge is made, the Participating Physician shall have no recourse to the Member for such charge.

III. The Corporation agrees to pay, and the Participating Physician agrees to accept, as full and final compensation, the amount specified in the Schedule of Surgical Operations (Section XIII), or any lesser amount deemed necessary by the Board of Directors of Connecticut Medical Service, Inc. and the Insurance Commissioner of the State of Connecticut to maintain the financial integrity of the Corporation, for the following:

1. Services rendered to the Member under the Service Benefit provision in Section VI, paragraph 2 of the REGULATIONS.

2. The credit allowed the Member under the Indemnity Benefit provisions in Section VI, paragraph 3a of the REGULATIONS.

IV. This Agreement shall be for a period of one year from its effective date, and thereafter shall continue indefinitely until cancelled by either party upon sixty (60) days prior written notice to the other.

Signature: .....M.D.

Address: .....

.....

Connecticut Medical Service, Inc.

Approved.....

Date.....

AGREEMENT OF CONNECTICUT HOSPITAL SERVICE, INC. TO ACT AS CONTRACTING AGENCY FOR CONNECTICUT MEDICAL SERVICE, INC.

This Agreement is made this.....day of ..... 194..... in accordance with Special Act No. 284, Connecticut Special Acts of 1945 by virtue of which Connecticut Hospital Service, Inc. is authorized to contract with and act as agent for medical service corporations.

It is agreed that Connecticut Hospital Service, Inc., hereinafter called Hospital Plan, will act as sole agent for Connecticut Medical Service, Inc., hereinafter called Medical Plan, as hereinafter specified. This agency is created for the purpose of making available to the people of Connecticut certain medical services on a prepaid, low cost, nonprofit basis.

I. The Hospital Plan shall serve as agent of the Medical Plan in such things as the enrollment of members (who shall be limited to enrolled members of the Hospital Plan), underwriting procedures, public relations (not professional relations), collection of subscription charges, maintenance of certain records and in general the administration of any of the affairs of the Medical Plan mutually agreed upon from time to time by both Corporations, except those excluded in Section VII. However, nothing contained in this Agreement shall affect the separate identity of the two Corporations, nor shall this Agreement affect any functions of the Hospital Plan other than its function as agent for the Medical Plan.

II. It is agreed that the Medical Plan shall not contract with any organization other than the Hospital Plan for the solicitation or enrollment of members or for the rendition of any other services specified in this agreement. It is also agreed that the Hospital Plan shall not contract to act as agent for any other prepaid medical service.

III. All the records maintained by the Hospital Plan as agent for Medical Plan shall be kept by the Hospital Plan in the form and to the extent mutually agreed upon and deemed advisable by both parties hereto. Such records shall be subject to audit by the Insurance Commissioner of the State of Connecticut and by any Certified Public Accountant mutually acceptable to both parties hereto.

IV. Subscribers shall pay Medical Plan membership charges to the Hospital Plan on the basis of billings rendered by said agency. The Hospital Plan shall remit all Medical Plan membership payments to the Medical Plan.

V. The actual costs of the agency function of the Hospital Plan shall be paid to the Hospital Plan by the Medical Plan without profit or loss to the Hospital Plan in a manner mutually agreeable to the Hospital Plan and to the Medical Plan. The only liability of the Hospital Plan hereunder shall be to account for the membership fees actually received by it in payment of Medical Plan membership.

VI. Except as specified herein neither party to this Agreement shall, under any circumstances, be liable or responsible for the debts and obligations of the other, nor shall either party be liable for any contracts made and issued by the other, or for standards of service rendered or for performance by the other.

VII. The Medical Plan shall be directly responsible for and shall perform the following functions:

1. All relationship with physicians or group of physicians, other than the purely mechanical procedures performed by the agency function of the Hospital Plan.

2. The consideration and payment of claims for benefits under the Medical Plan contract; except that the agency function of the Hospital Plan will, upon request of the Medical Plan, provide the Medical Plan membership status of the claimant.

3. The maintenance of accounts payable for professional services rendered to members.

4. Its own statistical data and reports other than basic records requested of the Hospital Plan.

5. The maintenance of the general accounts of the Medical Plan.

VIII. It is recognized that general policies and operating details of both corporations interlock to a large degree; that such policies and operating details, Boards of Directors and operating staffs, must be coordinated through a single person acting as chief operating executive for both corporations. It is therefore agreed that the General Manager of Connecticut Hospital Service, Inc. shall also act as the chief operating executive of Connecticut Medical Service, Inc.

IX. This Agreement may be terminated by either party hereto by giving to the other ninety days prior written notice.

THE DOCTOR'S OFFICE

Jerome S. Beloff, M.D., announces the removal of his office for the practice of pediatrics to 213 East Main Street, Meriden.

Henry J. Gloetzner, M.D., announces the opening of an office for the practice of internal medicine in the Medical Arts Building, Norwalk.

Beckett Howorth, M.D., announces the opening of an office for the practice of orthopedic surgery at 126 Bedford Street, Stamford.

John J. Korab, M.D., announces the opening of an office for the practice of internal medicine at 66 South Street, Middletown.

Herbert D. Lewis, M.D., announces the opening of an office for the practice of internal medicine at 107 Whitney Avenue, New Haven.

Steven P. Magyar, M.D., announces the opening of an office for the practice of surgery at 79 Trumbull Street, New Haven.

Henry J. Messinger, M.D., announces the opening of an office for the practice of medicine and surgery in the Sullivan Building, Post Road, Fairfield.

John P. Riesman, M.D., announces the opening of an office for the practice of surgery at 57 Trumbull Street, New Hvaen.

A. Rocke Robertson, M.D., announces the opening of an office for the practice of obstetrics and gynecology at 106 Litchfield Street, Torrington.

Joseph W. Saidel, M.D., announces the opening of an office for the general practice of medicine at 2151 Park Avenue, Bridgeport.

Hoyt C. Taylor, M.D., announces the removal of his office for the practice of obstetrics and gynecology to 213 East Main Street, Meriden.

J. Alexander Van Heuven, M.D., announces the opening of an office for the practice of ophthalmology at 85 Whitney Avenue, New Haven.

Red Cross National Blood Program

The National Blood Program of the American Red Cross "will operate successfully only if the doctors in your communities believe in it" Dr. Ross T. McIntire, national administrator for the program, told approximately 200 members and volunteer workers of the New Haven Chapter at their annual meeting October 27 in the Yale Law School auditorium.

The retired surgeon general of the Navy and former White House physician declared that Connecticut has been selected as one of the first states in which a blood center will be established by the Red Cross. Plans call for its establishment in either Hartford or New Haven, and await final selection of the location by the state organization, he said.

In developing the program "a great deal of consideration must be given to the smaller towns, since they are probably more in need of blood plasma and derivatives than the larger cities," Dr. McIntire declared.

He emphasized that the program is designed for peacetime use. "We are not giving proper thought to our children in their formative years," he said, and cited illnesses among children which could be treated more effectively if adequate blood supplies existed throughout the country.

He said the Connecticut program should have as its first objective the familiarization of all Red Cross chapters in the state with the operating procedures of the blood center. He told volunteer workers that initiation of the program "will mean hard work, from ringing doorbells to conducting community educational programs so that people will realize that if our citizenry is to remain strong an adequate blood program is essential."

Members of the meeting were welcomed by New Haven's Mayor, William C. Celentano, who commended the work of the Red Cross Disaster Committee and the organization's help in administering aid during the fuel shortage in the city last winter.

At the annual business session G. Gordon Copeland, treasurer of the Southern New England Telephone Company, was re-elected chairman of the New Haven Chapter of the organization.

Improve Streptomycin Therapy for TB

The toxic effect of streptomycin therapy for tuberculosis has been significantly alleviated, according to a report of the Council on Pharmacy and Chemistry of the American Medical Association. The report appears in the issue of *The Journal of the American Medical Association* for October 23.

The complete paper upon which the report is based was prepared by the Streptomycin Committee of the Veterans Administration, at the request of 48 Veterans Administration, Army, and Navy hospitals that cooperated in a study of the use of streptomycin in treating tuberculosis.

The report says:

"The most significant practical development of the past year is concerned with new regimens. It has been found possible to reduce the daily dose of two grams for 120 days to one gram for the same period, with a decided reduction in toxicity and without detectable loss of therapeutic efficacy. This reduced dosage is as effectve when given in two daily injections as in five.

"A further reduction in daily dosage to half a gram would not appear to be very significant. A reduction in the duration of treatment to 60 days while maintaining the daily dosage at two grams was accomplished without any observable diminution in effectiveness. With the disadvantage of toxicity thus alleviated, if not removed, the main bugaboo of streptomycin therapy lies in the development of resistance by the tubercle bacilli."

A series of 2,780 patients was studied. Concerning the results of treating pulmonary tuberculosis with streptomycin, the report says:

"In the main infection, pulmonary tuberculosis, streptomycin therapy with bed rest is still regarded as a useful aid to other forms of treatment. Its ability to reverse the trend of progressive exudative lesions has been observed in about 80 per cent of patients treated with all regimens. Occasionally, the clearing is complete; in the great majority of instances the clearing is incomplete and, often, only temporary.

"Unless the clearing is complete and permanent, the role of streptomycin appears to be to make possible the use of collapse procedures which, in the absence of streptomycin therapy, would have had to be delayed or could never have been performed.

"The type of lesion is carefully selected. The unsuitability of many patients with pulmonary tuberculosis for streptomycin therapy is evidenced by the observation that, although nine out of 10 cases of tuberculosis in Veterans Administration hospitals are of this type. in only one-third (943 out of 2,780) of the diseases covered by this report was treatment given for the pulmonary disease.

"Clearing which has been recorded as 'improvement' is partial and only rarely complete. The percentage of relapses which occur after improvement during treatment (7 to 10 per cent) and following treatment (14 to 29 per cent) is considerable."

Of the 943 patients treated with streptomycin for pulmonary tuberculosis, 71 to 75 per cent were judged improved during therapy. Nine to 13 per cent of the 943 patients were judged improving before therapy.

Early results of treating miliary and meningeal tuberculosis with streptomycin were "startling," but the later results were much less favorable, the report states. The study shows that streptomycin therapy makes the prospects "rather brighter" in genitourinary and orthopedic tuberculosis. Superficial lesions of the skin, sinus, and other locations healed or improved remarkably, and occasionally reappeared after streptomycin therapy.

The American Medical Writers' Associaiton

The Mississippi Valley Medical Editors' Association has now become The American Medical Writers' Association. The purpose of the Association is defined as: "(a) to bring into one organization all physicians interested in medical journalism or medical writing, and all laymen who are connected with the editorial or business staff of medical periodicals, libraries, foundations, or publishing companies; (b) to help improve medical literature; (c) to secure interchange of views of the members so that they may attain such intelligent unity and harmony in every phase of their labor as will elevate and make effective the opinions of the medical profession in their respective communities."

Under this new name it is hoped to include all medical men interested in medical writing even though they may not be editors. It is planned to hold the meetings for the next few years in the middle west.

CONNECTICUT CANCER SOCIETY'S NURSING REIMBURSEMENT PLAN

A Report of the First Year

EDWIN R. MEISS, *Managing Director*

ON September 1, 1947, the Connecticut Cancer Society put into effect a plan for the reimbursement of nursing agencies for cancer bedside nursing not otherwise paid for. It is now possible to report on the operation of this plan for the period of a full year during which the Society has paid $71,786.44 for this service to cancer patients. The plan was recommended by the State Society's Medical Advisory Committee and worked out in cooperation with a special committee of the Board Members Organization of Public Health Nursing Agencies.

The Society realized that nursing agencies have cared for cancer patients in the past as part of their community responsibility and would continue to do so in the future. It also was aware that many patients paid for visiting nurse service and that other visits were regularly paid for by insurance companies and through old age assistance. The aim of the plan was to enable nursing agencies to increase their care in the home despite mounting budget costs, because they would be assured of payment on a per visit basis. A special application form was provided to all Public Health Nursing Agencies on which to make quarterly requests for service rendered. Visits were paid for on the basis of the insurance audited cost or, where no such audit existed, on the basis of the regular charge of the nursing agency.

During the year, fifty-four agencies applied for reimbursement. This constituted approximately half the Public Health Nursing Agencies in the state and included virtually all the larger ones. It is assumed that the remaining agencies either had no cancer cases or had none which were not paid for from other sources. The total number of cancer visits reported by these fifty-four agencies during the year was 19,268 and the total cost of these to the agencies was $27,247.93. The agencies received specific payment for these visits from other sources in the amount of $10,656.99. The Connecticut Cancer Society paid a total of $16,590.94, the balance of the cost of these visits. Added to this was a special feature providing payment for nursing service rendered in the Tumor Clinics by Public Health Nursing Agencies. At $1.50 per hour, a total of 797 hours of service were rendered and paid for in the amount of $1,195.50, making the grand total above mentioned of $17,786.44. The Cancer Society thus entered the field as a new source of funds and paid for 66 per cent of the visiting nurse cost of cancer service.

It was hoped that by increasing bedside nursing visits the family of the cancer patient might have its situation eased and in many cases the patient might be kept at home in more familiar surroundings rather than be institutionalized. This would be helpful in relieving the over-crowded conditions in hospitals and convalescent homes. It was also expected that the visiting nurse, as an ally of the Cancer Society, would continue to improve her alertness to possible cancer symptoms and be the agent for the Society's educational function to promote early diagnosis. There are many indications that this confidence was justified. From a humanitarian point of view the Society was extremely interested in being able to increase the comfort and care of cancer patients. According to the reports of the 54 agencies, the number of cases they were serving at the beginning of the year was 241. During the year 937 were added and 79 were reopened, making a total of 1,257 cases. Discharged during the year were 918, leaving 339 cases active at the end of the 12 month period. The sources of referral for these cases were most often the physician and the family, with the Tumor Clinics running third, followed by the Visiting Nurse Association and other social agencies.

Obviously the cost of nursing visits was only a small part of the medical cost incurred in the care of all these patients. The Cancer Society is being asked increasingly to give financial aid in all phases, whether for medication, hospitalization, or related purposes. Comparatively small sums are available, best suited for emergency aid such as transportation and dressings; but it is becoming evident that adequate relief—besides being the responsibility of official agencies—is far beyond the financial ability of the Society to provide. It is estimated that cancer costs the families of patients in America some $900,000,000 per year. The American Cancer

Society nationally raised in 1948, its most successful campaign, a total of $13,000,000.

Research to find the cause and cure of cancer, and education to save lives with present knowledge through early diagnosis, holds a promise for the future and constitute important functions for the use of the Society's funds. The question of financial aid and direct service to patients, therefore, must have the most careful scrutiny in the light of funds available. With this in mind, the quarterly requests of the Public Health Nursing Associations offer a challenge. Along with the cost of most other things, the cost per visit of nursing service during the year rose from an average of $1.19 in the first quarter to $1.505 in the fourth quarter. While the number of applying agencies increased only slightly, the total amount applied for increased steadily during the year as follows:

First quarter	$3,192.98
Second quarter	3,462.37
Third quarter	5,209.16
Fourth quarter	5,921.93

The Connecticut Cancer Society has had an unprecedented number of requests for valid projects in excess of the funds it had available from the 1948 campaign. It has set aside $16,000 to continue the Nursing Reimbursement Plan for the current fiscal year. The plan has been continued unchanged, but the experience of the early quarters of the year may confront the Society with the necessity of adjusting the plan to the funds available. In any case, the officers of the Society feel that this has been a most worthwhile project in promoting the welfare of the cancer patient and in helping the Public Health Nursing Associations to meet community responsibilities in the heartening work in which they are engaged.

From Our Exchanges

W. H. Stoner writing in *The Journal of the Medical Society of New Jersey*, September 1948, concludes that, on the basis of certain established physiological responses in the interaction of the pituitary, the gonads and the adrenal cortex, hormones accelerate or retard the utilization of foodstuffs—including carbohydrates. Although diabetes mellitus occurs even in the absence of pancreatic disease, only insulin specifically controls the disease. However, both estrogenic and androgenic, possibly also cortical steroids, are useful adjuncts particularly in juvenile and climacteric diabetes when they are difficult to control with insulin alone. (This is an informative article which will fully repay any reader's time. Ed.)

An article by Hufford and Burns in response to numerous requests for information about the practical application of the Papanicolaou test appeared in *The Ohio State Medical Journal*, September 1948. 2,461 women have thus far been enrolled in the program conducted by the State committee on cancer. When used as a community program the method discovers early, even symptomless uterine carcinoma. But the authors say: (1) The test is not a substitute for biopsy; if there is suspicion a biopsy should be done even in the face of a negative test. (2) It is not diagnostic, being only a screen test pointing the way for further definitive procedures. Therapuetic measures should not be taken without confirmation of the smear findings, by biopsy. (3) Its special value is in two types of cases: a. The clinically suspicious case where it aids in selecting cases for biopsy. b. The clinically well case where it may detect carcinoma before signs or symptoms occur.

After reviewing several theories about the mechanisms of Raynaud's disease, Fox & Leslie in *The Wisconsin Medical Journal*, September 1948, report two case histories on the treatment of Raynaud's Disease. At the suggestion of Adson of the Mayo Clinic, these cases were treated with local application of 2 per cent nitroglycerine in Canolin. The results were so encouraging as to warrant reporting these cases, especially since both had resisted previous therapeutic efforts. The need is for local vasodilatation and this has been sought by sympathectomy, but in about 50 per cent of the cases this operation has been disappointing. Hence the desirability of trying other measures.

The Bulletin of the National Tuberculosis Association, September 1948, carries a frank plea for more consideration of the patient as a person, entitled "TB Patients Are People" and written by Paul Dufault. The doctor's attitude influences the patient favorably or unfavorably. He must acquire the acuity necessary to detect the presence of the inner being whose pulsations should not be permitted to go unrecognized and unattended.

DIABETES DETECTION DRIVE

of the American Diabetes Association, Inc., Initiated by Diabetes Week, December 6-12, 1948

DIABETES IN AMERICA—CURRENT PROBLEMS AND NEEDS

The increasing importance of diabetes mellitus in the American population has been born in upon physcians interested in diabetes for a number of years. Pilot surveys during and since the war have shown that a large number of patients have diabetes without knowing it and that they may be protected against future complications of this condition if they can but receive the benefits of recent discoveries, particularly in the field of dietary treatment and the new forms of insulin. The American Medical Association and its component state and county medical societies are aware of this challenging opportunity and their diabetes committees will strive to extend public information about diabetes. Provision for diagnostic tests of blood and urine for diabetes should become more generally available. The cooperation of physicians and allied professions, educators, the press, radio and all interested citizens is invited.

THE MAGNITUDE AND NATURE OF THE PROBLEM

There are probably 2,000,000 diabetics in the United States, and their number is steadily increasing. About 1,000,000 have been identified and most of these are under treatment. The other 1,000,000 have not yet had their disease discovered. The number of potential diabetics is even greater. Over 4,000,000, or about 3 per cent of our population, may eventually become diabetic.

Diabetes is a major chronic disease. In numbers affected, it is outranked only by heart disease and its related blood vessel and kidney disorders, and by cancer and rheumatism. It is eighth in rank among the causes of death.

Diabetes may strike at any age, although it is most common after 40.

Diabetes is unique among the diseases common in middle and later life in that insulin provides a specific means of control. No comparable specific treatment is available for any other major disease.

Executive office, 1 Nevins Street, Brooklyn 17, New York. Committee on Diabetes Detection, 81 Bay State Road, Boston 15, Massachusetts.

MAJOR TASKS IN DIABETES TODAY

1. *To find the 1,000,000 unknown diabetics.*

Early discovery of diabetes pays enormously. The disease is usually mild at the beginning, but if untreated, is likely to progress. If given treatment in time, the threat to life and the risk of crippling complications may be avoided.

2. *To get the best treatment to all diabetics.*

Insulin and other measures in the management of diabetes make possible a virtually normal level of health and activity. Nevertheless, thousands of known diabetics are not getting the best that modern medical science affords. They suffer the same severe complications as the undiscovered diabetic. Sound programs of professional and patient education will remedy this situation.

3. *To find better methods of treatment and to solve the problem of premature aging in diabetes.*

a. *Insulin.*

Present types of injected insulin do not have the same automatic action (i.e., release in the right amount in response to the rise in blood sugar) as the natural insulin supplied by the pancreas. Research on an injected insulin that will have or will approximate this automatic action is projected. Generous support of this research will speed its discovery.

b. *Causes of premature aging in diabetes.*

As many as two-thirds of the deaths among diabetics today are caused by arteriosclerosis (hardening of the arteries). *In youth, it is ten times as common in the diabetic as in the non diabetic.* In the diabetic, it manifests itself prematurely and causes serious complications. Among these are blindness, gangrene, coronary disease and Bright's disease. The solution of the problem of arteriosclerosis in diabetes would be of far reaching importance. *It would benefit all mankind, not merely diabetics, by showing how old age might be deferred.* Study of the problem in diabetics is most likely to yield the best material for research simply because arteriosclerosis often develops so early and so rapidly in diabetics. In them, these changes can be traced from their very onset.

4. *Prevention of diabetes.*

Most susceptible to diabetes are overweight middle-aged persons, particularly women, with a family history of diabetes. Emphasis on the dangers of overweight and the special value of periodic health check-ups for this group will be most effective to prevent or at least postpone the disease.

THE AMERICAN DIABETES ASSOCIATION

These urgent problems are being attacked by the American Diabetes Association, the only national organization in its field. The Association is a non profit organization, dependent upon financial support from membership dues and donations. Its membership is made up largely of physicians. Founded in 1940, the Association now includes 1,000 physicians engaged in directing diabetes clinics, treating patients, teaching diabetes, and conducting research on the disease.

Its Council, which includes its ex-presidents, represents all parts of the United States and Canada. These men have all made important contributions to the study and treatment of the disease. Dr. C. H. Best, co-discoverer of insulin with Banting, and now professor of physiology and director of the Banting Institute at the University of Toronto, is president of the Association.

The chief objectives of this Association are to improve the treatment of diabetes, to bring the newest knowledge of the disease to all physicians, to encourage and support research in the field, and to increase knowledge of diabetes among the general public.

The Association is at the present furthering its program largely through the following agencies:

1. *Local Diabetes Associations.*

There are now 45 such groups in various cities and states. Their membership, chiefly medical, also includes, in some localities, public-spirited laymen. Their purpose is to promote both professional and lay education on diabetes at the local level, as well as to give support to the major projects of the national Association. Organization of local societies in every state and metropolitan center is an aim of the national Association.

2. *Diabetes Clinics.*

Diabetes clinics for outpatients are already in existence in hospitals in many cities, 73 in New York City alone. To meet minimum needs the national Association is pressing for the establishment of additional clinics. It is also assisting local clinics to improve the quality of their service and has helped this movement by recommending standardization of procedures. Most of them need additional personnel and laboratory equipment.

3. *Publications.*

a. *A.D.A. Forecast,* a journal for diabetic patients.

This magazine began publication in January 1948. Through its columns it will be possible to disseminate information widely to diabetics everywhere, to emphasize the need for continuous medical supervision, and to stimulate diabetics to adhere faithfully to the prescribed treatment.

b. *Diabetes Abstracts,* a professional journal.

This is a quarterly publication of the Association, now in its seventh year. It summarizes new medical articles on diabetes published in every country in the world. It contains also editorial comment on major concepts and trends in the disease as well as recent statistical data.

c. *Proceedings* of the American Diabetes Association.

This is an annual volume containing the scientific papers given at the annual meetings of the Association. Because of the high caliber of many of these papers, these volumes are used as reference texts by all medical schools in the United States and Canada.

4. *Encouragement and Support of Research*

The Association aims to obtain sufficient funds to initiate and support organized research from its own resources. It can perform a vital service by coordinating research because its membership includes the outstanding investigators and clinicians. A group of its members are already so engaged, acting as advisors to the Study Section on Metabolism and Endocrinology of the United States Public Health Service. This group will be the nucleus for a Research Committee of the Association, when it obtains sufficient research funds.

ASSOCIATION OBJECTIVES REQUIRING FINANCIAL AID

1. *Case Finding in Diabetes.*

The search for the million unknown diabetics is a fundamental objective of the American Diabetes Association, in cooperation with its local affiliates, Departments of Health, and practicing physicians. The attainment of this objective will be furthered by an annual Diabetes Discovery Campaign, as

already projected by the Association, and also by continuous propaganda for periodic health examinations, which include urinalysis and, as necessary, blood analysis.

2. *Educational Programs.*

a. *Professional.*

The modern treatment of diabetes is relatively new. Consequently, doctors who came out of medical school more than 20 years ago had no undergraduate training in the currently approved methods of treatment. Postgraduate or refresher courses in diabetes are necessary so that those in medical or auxiliary professions can be kept abreast of advances in the field. In like manner, there is need for improving the teaching of diabetes in medical, nursing and dietetic schools.

b. *Lay Education.*

The control of diabetes depends upon a careful balance of diet, exercise (or work) and insulin. Not all patients require injections of insulin, but for those who do, insulin may be life-saving. The best results in treating diabetes are achieved by thorough schooling of patients in the fundamentals of their disease and by helping them to shoulder the major responsibility for maintaining their health. Group and individual teaching of diabetics in the details of treatment should be greatly extended. It should be systematic and make use of the most up-to-date educational methods, including films and other visual instruction aids. There is as yet no first-class film on diabetes.

3. *Camps for Diabetic Children.*

The camp for diabetic children has proved its value in their education. In the camp, they learn more about the management of their disorder and get encouragement from each other, as well as obtain the benefit of continuous medical supervision in good surroundings. The building of morale that is accomplished by the stay at camp successfully breaks down the sense of inferiority engendered in these children by their disorder. Diabetic children can go to no other camps without special care. Only a few diabetic camps have been established. Many more are needed. Moreover, such facilities may also be found valuable for adult diabetics. The Association proposes to help local groups organize such camps and put them on a sound basis medically and financially. These camps are expensive, because they require laboratory and dietetic facilities and nursing staffs.

4. *A.D.A. Forecast.*

This publication requires financial help in order to increase its circulation among diabetics and thus to realize its full potentialities.

5. *Extension of Laboratory Services.*

As already noted, these are often either lacking or not operated at full efficiency. Diagnosis and treatment of diabetes will take a great forward step when these deficiencies are corrected.

6. *Research.*

Research along the lines described will be systematically concentrated under the direction of the outstanding investigators in the field who are already members of the American Diabetes Association.

Connecticut Diabetes Association

The Connecticut Diabetes Association, in cooperation with the American Diabetes Association, is planning a campaign to promote the early discovery of presently unknown cases of diabetes.

Dr. Barnett Greenhouse, New Haven, president of the Connecticut Association, has announced that the campaign will be launched in observance of the nation's first annual Diabetes Week, December 6 through December 12.

The campaign will continue throughout the year as one of the major activities of the association, in cooperation with the national plan being sponsored by the American Diabetes Association of which the Connecticut organization is an affiliate.

The Connecticut Diabetes Association now numbers more than 300 physician members, and county chapters are in process of organization. It is planned to request local health departments to conduct blood sugar and urine screening tests as a feature of the program for Diabetes Week. Under no conditions will reports of the tests be sent to the examinee, since the effort is to bring the unknown diabetic patient under his own physician's care, it is explained.

In line with the national program, the long range objective will be to promote urine and blood sugar examinations for everyone through simplified tests. Special equipment has been developed for these tests, and will soon be in production by the manufacturer, the national association has announced.

The officers of the Connecticut Association are as follows: Barnett Greenhouse, M.D., president, New Haven; Burdette J. Buck, M.D., 1st vice-president,

Hartford; Anthony Cipriano, M.D., 2nd vice-president, New Haven; John Dobkins, M.D., secretary, Stamford.

Dr. Senn New Head of Yale Child Clinic

President Charles Seymour of Yale University has announced the appointment of Dr. Milton J. E. Senn as director of the new Yale Child Study Center.

The new center will include the Yale Clinic of Child Development which was established by Dr. Arnold Gesell. Dr. Gesell retired as professor of child hygiene on July 1.

Dr. Senn comes to Yale from his post as director of the Institute of Child Development and professor of pediatrics in psychiatry at the Cornell University Medical College. At Yale, he will be Sterling professor of pediatrics and psychiatry.

The new Yale Child Study Center will help to guide parents, teachers and other persons concerned with the problems of children. It will contain a guidance nursery, film library and clinical resources to supply research and teaching media for students from professional disciplines interested in the growth, development, behavior and personality of human beings. It will expand facilities for graduate work and research.

Dr. Senn has shown that the pediatrician must be trained not only in the field of medicine in order to treat illness but also in the field of psychiatry to understand the relationships which every child has with his parents, teachers and others. He also has brought to people in the field of psychiatry a new insight into pediatrics.

He is the author with Phyllis K. Newill of a book, "All About Feeding Children," which was published in 1944 and has written articles for scientific journals on the relationship of psychiatry to pediatrics, pediatric education, and the management of sick children.

Born in Milwaukee, Wisconsin, he received both B.S. and M.D. degrees from the University of Wisconsin. He received his intern training at the Columbia and Milwaukee Children's Hospital from 1927 to 1929 and during the next year was an intern and fellow in pediatrics at the St. Louis Children's Hospital in St. Louis, Missouri.

From 1930 to 1933 he was an instructor in pediatrics at Washington University in St. Louis and from 1933 to 1939 served as an associate in pediatrics at the Cornell University Medical College. From 1937 to 1939 he served as a Commonwealth Fund Fellow in psychiatry at the New York Hospital—Westchester Division and the Philadelphia Child Guidance Clinic.

He was promoted to assistant professor of pediatrics (psychiatry) at Cornell in 1939 and in 1942 to associate professor of pediatrics in psychiatry. He was made director of the Institute of Child Development at Cornell University Medical College last year and was promoted to full professor.

He is a member of The American Pediatrics Society, The American Psychiatric Association, The American Academy of Pediatrics, and the New York Academy of Medicine.

Dr. Buol Heads New Britain TB Association

Based on a long range plan for an expanded tuberculosis control program in New Britain through community health education, case finding and rehabilitation, the New Britain Tuberculosis Association, Incorporated, completed its organization in October with Dr. Robert S. Buol elected as its first president.

The newly organized Association is the result of a decision made last spring by the Board of Directors of the New Britain Tuberculosis Relief Society to reorganize on a broader basis, permitting wider community participation in New Britain's public health program.

A Joint Committee headed by Mr. Maxwell A. Coe, president of the Society, and composed of members of the Society's Board of Directors and the Connecticut Tuberculosis Association began work late last spring on a plan for complete reorganization following the Society's relinquishing to the New Britain Health Department its tuberculosis clinic, supported for many years with Christmas Seal funds.

Local persons serving on the Joint Committee for Reorganization were Mr. John L. Doyle, superintendent of public welfare; Miss Rachel C. Colby, director, Visiting Nurse Association; Dr. Robert S. Buol, Dr. Louis J. Dumont, health officer, and Mrs. Howard S. Parsons.

Dr. Philip J. Moorad, vice-chairman of the health division, Council of Social Agencies, served as chairman of a committee on Constituton and By-Laws. Other officers elected to serve until the first annual meeting were: Dr. Philip J. Moorad, vice-president; Mr. Frederick J. C. Ensworth, treasurer; Mrs. William T. Coholan, secretary. Dr. Louis J. Du-

mont, Mrs. Charles F. Stanley, Mr. Joseph F. Kozakiewicz, and the officers comprise the executive committee.

As New Britain's official Christmas Seal agency the Association will develop its activities according to Authorized Forms of Tuberculosis Work, as approved by the National Tuberculosis Association and will cooperate closely with the medical profession and all voluntary and official agencies concerned with the prevention and control of tuberculosis.

Dr. Gesell Heads Child Vision Research Project

Dr. Arnold Gesell, one of the world's most prominent authorities in the field of child behavior who retired as director of the Yale Clinic of Child Development on July 1, will continue his research at the University in charge of a Child Vision Research Project.

Work on child vision has been carried on as part of the general program of the Clinic of Child Development, in close association with its Guidance Nursery and Diagnostic Service for the past four years. It is supported by a grant from The American Optical Co.

At Yale, the normal development of visual functions in infants and children is being explored by means of periodic examinations during the first ten years of life. The investigations are concerned especially with the growth aspects of vision and associated behavior.

During the current year the major research will be continued by Dr. Frances L. Ilg and Glenna E. Bullis under the direction of Dr. Gesell.

Author of two dozen important volumes on child psychology and child growth, Dr. Gesell holds both PH.D. and M.D. degrees. He has been a member of the Yale faculty since 1911 and has been a Professor of Child Hygiene since 1915. In addition to publishing numerous volumes on normal and defective children, exceptional children and their education, handicapped children in school and court, mental growth of infants and children, learning and growth of identical infant twins, treatises on experimental psychology, and an atlas of infant behavior, Dr. Gesell established in 1925 the photographic library of the Yale Films of Child Development. He has supervised the production of scientific and educational motion picture films at the University since 1930.

He holds an honorary Doctor of Science degree from Clark University and was a member of the White House Conference on Child Health and Protection and the White House Conference on Children in a Democracy. He served as school psychologist for the Connecticut State Board of Education from 1915 to 1919 and as a member of the Connecticut Commission on Child Welfare from 1919 to 1921. He is a member of the Connecticut Society for Mental Hygiene and a Fellow of the American Association for the Advancement of Science, the American Medical Association, and the American Orthopsychiatric Association. In addition, he is a member of many national medical and scientific societies.

Dr. J. D. McGaughey Honored by Wallingford

James D. McGaughey, a general practitioner in Wallingford since 1910, has been selected as that town's outstanding citizen for 1948. This award to Dr. McGaughey was sponsored by Leonard Golub Post, Jewish War Veterans. An inscribed plaque in recognition of his eminent standing in the community was presented to Dr. McGaughey at a banquet tendered him on November 16 at Oakdale Tavern. Dr. McGaughey was selected for his "contribution to making Wallingford a better place in which to live and work, and carrying out the principles of tolerance, democracy and good-will—principles for which veterans of all wars have fought and died."

Jim McGaughey is a native of Wallingford and received his elementary education there. He then attended Lawrenceville Academy, Yale University, and received his medical degree from Jefferson in 1909. After a period of intern work in Reading General Hospital, Reading, Pa., he returned to Wallingford in 1910, and has been a general practitioner continuously since that time with the exception of time served in the U. S. Medical Corps in World War I. He entered service May 25, 1917 and was overseas for many months before being discharged with the rank of major in April 1919.

He has served as a water commissioner for the Borough, has been active in Rotary since it was organized and is a past president, and also is a past commander of Shaw-Sinon Post, American Legion. He also is a member of numerous medical societies and fraternal organizations.

Drs. Fulton and Winternitz Receive Awards

John F. Fulton, Sterling professor of physiology, and Milton C. Winternitz, professor of pathology, were among eight Connecticut scientists and engineers, five of them Yale faculty members, recently to receive the award of the President's Certificate of Merit for important contributions to national safety during World War II. The awards in New Haven were part of a nationwide recognition of the scientists and engineers who contributed their services through the Office of Research and Development. The distinction of their services is hinted in the citation in recognition of "a contribution to our joint safety and future greatness beyond the ability of most men to achieve."

Dr. Fulton was cited for his six years of outstanding services in the field of aviation medicine. He was chairman of a committee on decompression sickness and served on a committee charged with the study of the whole field of aviation medicine. Dr. Winternitz was chairman of a committee on treatment of gas casualties as well as chairman of two other important committees.

Dr. Blumer Honored

The staff of St. Raphael's Hospital on October 5 feted Dr. George Blumer, outstanding clinician and an attending physician at the hospital until his recent retirement, at a testimonial dinner in the Lawn Club. Dr. Blumer now lives in California.

Coming to New Haven in 1907 as a professor at the Yale Medical School, Dr. Blumer was dean of the school from 1911 to 1921 and from 1921 to 1945, clinical professor of medicine there. 10 years ago he was considered one of the 10 outstanding American physicians.

Author of numerous monographs in clinical medicine, Dr. Blumer edited the well known "Foreshiner's Therapeutics" and "Blumer's Bedside Diagnosis." He also has been a frequent contributor to the JOURNAL, his editorials appearing over the initials "G. B."

Plan Special Tours for Atlantic City Meeting

The International Travel Service, Palmer House, 119 South State Street, Chicago, is organizing two interesting deluxe post-convention trips for AMA members attending the annual convention in Atlantic City, June 6 to 10, 1949.

Plans call for a special train to leave Chicago for Atlantic City on Saturday, June 4. The special will go directly to Atlantic City for the convention, leaving for New York on Friday morning, June 10. An evening of fun has been planned for the guests in New York that night. On Saturday evening, the party will depart on a delightfully planned trip into Canada by train and steamer.

In addition, the International Travel Service is planning an all expense airplane cruise to Bermuda from New York. This itinerary is flexible with departures on June 10, 11 and 12 for four, five or six-day visits. Guests will stay at the St. George hotel.

The rates of the AMA all-expense special tour by rail and steamer include first-class roundtrip railroad tickets in air-conditioned train. Pullman reservations as selected. Steamship cruise staterooms. Hotel rooms, double occupancy with bath, at the Waldorf, Mount Royal, Kent House and other hotels in Old Quebec City. Ample diners and club cars. Planned menus on the train, steamer, hotels and special restaurants (except while in New York and lunch in Montreal on Thursday, which time is left free for personal activities). A "tour conductor" will take care of all arrangements including transfer and baggage. Rate—(depending on Pullman selected) from 1 to an upper $284 each, to 2 in a drawing room $317 each.

The AMA all-expense air cruise from New York to Bermuda is flexible. The departure dates are June 10, 11 or 12. Stay on the Island of Bermuda is for 4, 5 or 6 days. A longer stay can be arranged if advised in advance. The St. George Hotel with its private beach, large inside swimming pool, nine hole golf course as well as dancing and entertainment facilities, makes a perfect setting for the AMA members who wish a cool and restful trip. Rates include: roundtrip airplane fare including taxes, rooms for double occupancy with bath, meals at the hotel and sightseeing. Rate—(depending on number of days) from $220 each for 4 days and $250 each for 6 days.

RESERVATIONS AND DEPOSITS

A deposit of $25 each is required for Tour Train or Airplane Cruise reservations. Final payment for Tour Train to be paid by April 1. For Airplane Cruise by May 1. If necessary to cancel, refund will be made in full with two weeks' notice. Make checks payable to, and mail with reservation request direct to International Travel Service, Inc., Palmer House, Chicago 3, Illinois.

Dr. Platt Heads Heart Group in Waterbury

Irving S. Platt was elected first president of the newly formed Waterbury Heart Society at a final organizational meeting of the group held on September 23. Other officers elected were vice-president, Jasper A. Smith; secretary, Thomas Monagan, and treasurer, P. J. Brennan.

The meeting was the final one of a series aimed at forming a group which will serve the Waterbury area in three ways:

1. In educating doctors and the public alike in the problems and treatment of the various diseases of the heart and blood vessels.

2. In improving facilities for care of these specific diseases.

3. In raising funds for the accomplishment of the first two aims.

A spokesman for the society said that one of the primary functions of the group's educational program will be to "give the physician a longer reach into the personal, specialized treatment of his patient." A list of speakers will be announced, who will address the society on various subjects relating to heart and blood pressure ailments, and member doctors hope eventually to set up their own speaker's bureau for addressing lay groups. The new society will meet once a month.

Dr. Platt heads the Board of Directors of the society, which announced that 35 charter members attended the organization meeting. Other directors are John H. Foster, J. L. Hetzel, J. A. Smith, A. S. Brown, Thomas Monagan and Max Ruby.

Course in Hospital Administration at Yale

With the aid of a grant from the W. K. Kellogg Foundation, a graduate course in hospital administration was established at Yale University in the Department of Public Health in recognition of the urgent need for hospital administrators with specialized training. The first class of eight students was admitted in September 1947 and completed the required year of academic work in June 1948. Thereafter, two of the students assumed administrative duties in general hospitals while six became administrative interns in similar institutions.

The course in hospital administration is an integral part of the teaching and research program of the Department of Public Health with the cooperation of the Grace-New Haven Community Hospital, certain University Schools and Departments, and hospitals and other agencies outside the University. It was designed to provide an understanding of the sphere of the hospital in the community and its place in the broad fields of public health and medical care, as well as of the vocational aspects of hospital management. Those eligible for admission are Doctors of Medicine, graduate nurses who have a bachelor's degree, and individuals who have a bachelor's degree without training in medicine or nursing. Some practical administrative experience in hospitals or other public health or medical care organizations is a prerequisite. Moreover, each applicant is required to present evidence of successful completion of a course in the fundamentals of accounting during at least one semester.

The total period of training requires twenty-one months. An administrative internship of twelve months in an approved hospital ordinarily follows the academic year of nine months at the University. An essay (thesis) covering a special field of study is required before the end of the internship. Upon successful completion of the course, physicians are eligible for the degree of Doctor of Public Health (in special cases only) or Master of Public Health, while other students are eligible for the Master of Public Health or Master of Science Degree.

The tuition for a candidate for the degree of Master of Science or Master of Public Health has been $450 for the academic year with incidental fees amounting to approximately $50. Married students have found apartments in the community at a rental of about $65 to $100 a month. Single furnished rooms have rented for about $7 to $10 weekly. Meals in the University Dining Hall were offered for $10 weekly; but it has not been convenient for students in this Department to take their meals there. The rates in commercial restaurants have been considerably higher. The majority of the students have been Veterans who have attended the University under the benefits of the G.I. Bill of Rights.

The curriculum of the course in public health for the current year includes the basic course in principles and practice of public health which was arranged to meet the needs of all students in the Department, regardless of whether they were preparing themselves to be public health administrators, health officers, or hospital administrators. Guest lecturers, field trips, and seminars are included.

In hospital organization and management the curriculum covers basic reading, hospital statistics,

detailed study of the various hospital departments, field trips, comprehensive administrative case study of a hospital, and two-hour conference periods.

Silver Hill Foundation Medical Council Meets

On the week end of October 15-17 the Medical Council of the Silver Hill Foundation met in New Canaan. The members, chosen to serve in an advisory capacity for a period of two years, met on the second afternoon in a scientific session led by William B. Terhune, medical director of the Foundation. Following this meeting the members, their wives and guests were entertained at the Country Club of New Canaan.

The following were present: Harold L. Amoss, Greenwich; Dana W. Atchley, New York; Walter A. Baetjer, Baltimore; Arlie V. Bock, Boston; Ralph H. Boots, New York; Russell Cecil, New York; Katherine and Kendall Elsom, Philadelphia; James Fox, Hartford; Cornelius F. Holton, Savannah; E. C. Jessup, Roslyn, L. I.; Walter O. Klingman, Charlottesville; Helen P. Langner, Milford; T. Grier Miller, Philadelphia; Irving H. Pardee, New York; Frank Hart Peters, New York; F. C. Redlich, New Haven; G. Gardiner Russell, Hartford; Dwight Siscoe, Boston; Warren I. Titus, Glen Cove, L. I.; Vernon Williams, Boston; Elihu S. Wing, Providence; Edwin G. Zabriskie, New York.

Other members of the Council are: Daniel Blain, Washington; John M. Bumstead, New Haven; Alexander Brugess, Providence; Joseph A. Capps, Chicago; Gray Carter, Greenwich; Henry W. Cave, New York; Howard Colwell, New Haven; Worth Daniels, Washington; C. Louis Fincke, Stamford; Walter Fishchel, St. Louis; Connie M. Guion, New York; Maurice Fremont-Smith, Boston; Ralph C. Hamill, Chicago; Leland P. Hawkins, Los Angeles; Thomas J. Heldt, Detroit; George Huffman, Washington; James E. Hutchison, Hartford; Milton Jena, Pittsburgh; John H. Keating, New York; Ralph A. Kinsella, St. Louis; William Kiser, Jr., Atlanta; Hilman O. Koefod, Santa Barbara; Paul V. Ledbetter, Houston; Asa L. Lincoln, New York; Frederick R. Lummis, Houston; Walter E. Lundblad, East Orange; Frank Luton, Nashville; John A. MacDonald, Indianapolis; Donald J. MacPherson, Boston; Edward E. Mayer, Pittsburgh; Arthur C. McCarty, Louisville; J. P. McComb, Pittsburgh; Johnson McGuire, Cincinnati; H. Houston Merritt, New York; John G. Merselis, South Orange; T. P. Murdock, Meriden; Arthur Neergaard, New York; Hulbert V. Noland, Lousville; Theodore S. Proxmire, Lake Forest, Illinois; William H. Resnik, Stamford; Henry A. Riley, New York; Arthur Ruggles, Providence; Eugene S. Talbot, Chicago; Otto G. Wiedman, Hartford; Rollin T. Woodyatt, Chicago.

The Silver Hill Foundation is a psychotherapeutic unit devoted to the study, care and treatment of the psychoneuroses where patients are given brief, intensive psychotherapeutic and physiological aid to re-establish their lives and their ability to work. The medical staff is composed of internists who, although they are Diplomates of the American Board of Psychiatry and Neurology, are interested in the eclectic approach to the treatment of the psychoneuroses rather than adhering to any one formal school of psychiatry. The subject for discussion of the Council this year was "What Is the Ideal Method of Treating the Psychoneuroses, Psychosomatic Illnesses and Psychosocial Disorders." Speakers were Drs. Amoss, Bock, Klingman, Redlich and Zabriskie.

Hartford Leads in Health Spending

According to figures released by the State Department of Health, Hartford led Connecticut's six major cities in the per capita expenditure of public health tax funds in 1947.

The city's expenditure per capita for public health from tax funds was $1.74, the Department reported. Similar expenditures for the other five cities were: New Britain, $1.30; New Haven, $1.26; Stamford, $1.25; Waterbury, 88 cents, and Bridgeport, 77 cents.

Hartford was the only one of the six largest cities to spend more than $1.50 in tax derived public health funds. The Department said that owing to rising costs, $1.50 should be the minimum amount per capita to supply communities with a basic full time public health service program.

Last year Connecticut's 169 communities spent $1,763,495 for public health services out of tax funds. This, the Department said, included all expenditures allocated from official local tax funds for public health services such as salaries, fees and expenses of local health officers, public health nurses, sanitary inspectors, meat inspectors, school physicians and nurses, school dentists and dental hygienists, and other public health personnel.

Also included were tax funds spent for venereal disease control, tuberculosis case finding, and local appropriations to visiting nurse associations. Not included were funds contributed by voluntary non-official health agencies.

A summary of past expenditures showed that the per capita amounts spent had increased from 77 cents in 1940 to 93 cents in 1947 on a statewide basis.

Summarizing the study, the Department concluded "that there are many Connecticut towns expending reasonable sums from tax funds for public health. Public health services in many of these remain, however, on a part time, and essentially an emergency basis. By the exercise of a little cooperation and suitable concerted action, improved services on a full time basis could be realized."

The Department pointed out that the 1947 Legislature passed "Health District Law" which enables small communities to join in setting up district departments of health, and providing state assistance for full time health programs.

Small Nurses Training Schools Inadequate

Dr. Esther Lucile Brown of the Russell Sage Foundation, New York, and lay author of the controversial report issued last year entitled "Nursing for the Future," made the statement at the recent annual convention of the Connecticut State Nurses Association that all nursing shools with enrolments of less than 50 students should be discontinued. Dr. Brown charged that "literally hundreds of schools of nursing in this country operate with less than 50 students, and these small schools provide a miserable training for nurses." Referring to the nursing shortage of today, she emphasized the need for quality as well as for quantity.

Dr. Brown declared that relatively few of the nation's nursing schools provide "even an adequate professional education." As a mean of discontinuing the poor schools Dr. Brown recommended a national agency for accreditation of nursing schools.

According to Dr. Brown the health centers of the future will require the services of several types of nurses. She envisions a nursing team which would include the professional nurse who would be college educated, the trained practical nurse, and the nurses' aide. She maintained that the education of the professional nurse belongs within the aegis of the university and not within a hospital. "What is needed," Dr. Brown said, "is an educated lay public to give financial, moral, and intellectual support to the cause of nursing and its advancement in the educational field." "The environment in nursing schools," she said, "must be improved, and standards of pay and hours raised." She disparaged the old apprenticeship system, under which students are used to doing hospital work rather than being taught to be nurses; she spoke forcefully against authoritarianism, formerly common to all schools.

Cites Fears of Federal Control

Speaking at the Harvard School of Public Health recently, Dr. James R. Miller, Hartford, a member of the Board of Trustees of the AMA, said that "even in public education there always has been a fear of federal control."

"In this connection," he added, "it is interesting to note that according to a report of a recent meeting of the American Association of School Administrators, representatives of 40 states launched a campaign to have the U. S. Office of Education made an independent agency of the federal government. In a statement to the press, President Willard E. Goslin stressed the fact that the Office of Education should be removed from 'political domination.'

"When representatives of a profession which has been accepted as a public function for over a century thus illustrate their fear, is it any wonder that physicians are concerned with the possible role of government in the practice of medicine?"

Connecticut Heart Association Forming

Preliminary plans for the formation of a Connecticut Heart Association were made at a meeting in New Haven on October 1. The session was called by H. M. Marvin, president-elect of the American Heart Association, and was attended by physicians from Waterbury, Bridgeport, New Haven, Hartford, Meriden, Greenwich, Danbury, Norwalk and Stamford.

Objectives of the association will be the same as those of the national organization, with which it will be affiliated if present plans materialize. They are education and research in the field of cardiovascular disease and increase in the facilities for treatment and care.

Dr. Marvin, who was named temporary chairman, will appoint committees for formation of the association.

NUMBERS WIN IN AMERICA

Majority rule is the foundation of free government. It rests on the proposition that individuals will exercise their franchise with care and wisdom.

But the busy modern citizen cannot act wisely when he does not receive reliable information.

It is vitally necessary that people be informed concerning the value of free medicine in America. Every physician can help make this information available.

Sound Information
Encourages Sound Action

Committee on Public Policy and Legislation
Fairfield County, John G. Frothingham, New Canaan
Hartford County, James R. Cullen, Hartford
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Richard F. Grant, Cromwell
New London County, Edmund L. Douglass, *Chairman* Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, William Schneider, Rockville
Windham County, William S. Maurer, Willimantic



PUBLIC AFFAIRS

MEDICAL CARE FOR BENEFICIARIES OF THE OFFICE OF COMMISSIONER OF WELFARE

W. H. Horton, M.D., *Medical Director*

The following information is issued to clarify current policies for the procurement of medical treatment and appliances in conjunction with the revised fee schedule, effective October 1, 1948, issued by the Department of Finance and Control and published in the November issue of the Journal.

1. *General Medical Services.*

Routine medical services involving office and house calls (both day and night), visits to convalescent and boarding homes for either general practitioners or specialists will not be altered except for the increases in fees noted in the schedule. Mileage will be allowed for out-of-town calls at the rate of ten cents per mile, one way.

2. *Payment for Medications.*

It is not the intention of the medical program that medication dispensed by attending physicians should be in competition with the existing agreement between the Connecticut Pharmaceutical Association and the Office of Commissioner of Welfare for the procurement of drug and sickroom supplies for beneficiaries of State agencies. It is, however, necessary to recognize the fact that certain medications must necessarily be given by the attending physician. It is not desirable to set any specific rule as to what charges for medications will be permitted, since certain drugs in small amounts have traditionally been dispensed by the attending practitioner and included in the basic charge for the visit. Where expensive drugs are employed, especially injectables such as liver extract, estrogenic hormones, penicillin, and others, they should be listed separately on the physician's bill if payment is to be expected. This listing should include the name of the drug, strength and amount of the dose as well as the indicated price. Such drug items will be submitted to the pharmacist in the medical office of the Commissioner of Welfare for reviewing as to the propriety of the charge, which must be in line with the drug procurement agreement referred to above. The extent to which the Office of Commissioner of Welfare may participate in reimbursing its beneficiaries for drugs so secured will depend upon the reasonableness of the items and charges submitted for payment by the attending physician. Where extended use of relatively expensive medications, such as those noted above, is contemplated, prior authorization for such charges should be secured from the Medical Director.

3. A. *Prosthetic Appliances.*

The following types of surgical appliances will be prescribed for the patient by the attending physician, and such request together with a cost estimate will be submitted to the Medical Director for approval before purchase is made: trusses, surgical corsets and garments, elastic stockings, and arch supports.

B. *Artificial Limbs and Hands.*

Patients requiring artificial limbs or hands or repair of existing prostheses will communicate with the district worker who will refer the request to the medical director where an appointment will be made for the beneficiary to be examined by the Rehabilitation Section of the Hospital for Chronic Illness.

C. *Wheel Chairs.*

Requests for wheel chairs will be referred through the district office to the medical director.

4. *Surgical Services.*

General surgical procedures (pages 5 through 9) in the fee schedule booklet will continue to be performed in State-aided hospitals except the following, which may be performed in the surgeon's office at his discretion. The fees listed (80 per cent of the fee shown in the fee schedule) will be considered a flat all-inclusive fee for the procedure and will cover such examinations and redressings as are necessary to the proper care of the patient.

General Surgery

Abscess incision and drainage	$ 4.00
Ulcer, surface excision	8.00
Septic finger (tendon sheath involvement)	12.00
Laceration, minor, including suturing	8.00
Cyst, sebaceous, removal	8.00
Biopsy, superficial	4.00
Microscopic examination of specimen	4.00
Glands, superficial, removal	8.00
Breast cyst or abscess, aspiration or incision and drainage	8.00
Toenail, ingrown, removal	16.00
Cystoscopy	
Observation	12.00
Ureteral catheterization	16.00
Laryngoscopy, diagnostic	8.00
Sigmoidoscopy	8.00
Esophagoscopy	20.00
Pleura, paracentesis	8.00
Refill of artificial pneumothorax	4.00
Abdomen, paracentesis	8.00
Hemorrhoids, injection treatment, complete procedure	20.00
Hemorrhoids, thrombosis, incision	4.00
Abscess, ischiorectal or perirectal drainage	16.00
Perianal abscess, drainage	4.00
Circumcision, except infant, with anesthesia	12.00
Lumbar puncture	4.00
Bartholin's gland, incision and drainage	4.00
Bartholin's gland, excision	20.00
Labial tumors and cysts, removal	16.00
Cauterization of cervix	8.00
Cervical polyp removal	4.00
Cornea, paracentesis	16.00
Conjunctival suture	12.00
Chalazion, excision	
Single	8.00
Multiple	20.00
Corneal ulcer, cauterization	4.00
Aural polyp	8.00
Paracentesis tympani	8.00
Nasal polyps, removal	8.00
Turbinectomy	8.00
Antrum puncture and irrigation	4.00

Amputations

Finger	
Single	12.00
Each additional	8.00
Toe	
Single	12.00
Each additional	8.00

Dislocations, closed

Carpal bone	
One	20.00
Each additional	8.00
Clavicle	20.00
Elbow	20.00
Finger	
One	4.00
Each additional	4.00
Hip	28.00
Knee	28.00
Mandible	8.00
Metacarpal bone	
One	12.00
Each additional	4.00
Metatarsal bone	
One	12.00
Each additional	4.00
Patella	12.00
Rib	8.00
Shoulder	20.00
Tarsal bone	
One	20.00
Each additional	8.00
Thumb	8.00
Toe	
One	4.00
Each additional	4.00

Simple fractures, closed

Lower jaw	20.00
Carpal bone	
One	20.00
Each additional	8.00
Clavicle	20.00
Coccyx	8.00
Finger	
One	8.00
Each additional	4.00
Metacarpal bone	
One	12.00
Each additional	8.00
Metatarsal bone	
One	12.00
Each additional	8.00
Patella, closed	20.00
Nasal bone or bones, reduction	20.00
Radius or ulna, or both	20.00
Rib, one or more	8.00
Scapula	20.00
Sternum	20.00
Tarsal bone	
One (exclude os calcis and astragalus)	20.00
Each additional	8.00
Toe	
One	8.00
Each additional	4.00

IMPORTANT NOTE

Procedures not listed in the above schedule which are included in the complete fee schedule will not be considered for payment as office procdeures without the specific prior authorization by the medical director except in emergencies. Procedures which are contemplated and which do not appear in the complete surgical schedule should not be performed without prior authorization from the medical director.

Truman and Ewing Accused of Using Medical Care For Politics

Dr. Morris Fishbein, Chicago, editor of *The Journal of the American Medical Association*, recently charged President Truman and Federal Security Administrator Oscar R. Ewing with attempting to use medical care as a political weapon.

In a speech prepared for delivery at the Silver Jubilee Dinner of the St. Louis University School of Medicine, Dr. Fishbein said that the Report on the Nation's Health, which Mr. Ewing made to the President, is a "shrewdly contrived document, designed to break down the confidence of the American people in their medical care."

Mr. Ewing "called a National Health Assembly, stacked his executive committee, and then sent a report which recommended compulsory sickness insurance because President Truman recommended it to him," Dr. Fishbein charged.

He made it plain that the program of citizen health councils in every state and community and a nationwide compulsory sickness insurance system which the report proposes was not originated by the National Health Assembly.

"While Mr. Ewing and his fellow bureaucrats have been trying to create a political machine based on a nationwide health service," Dr. Fishbein told the group, "the medical profession and most of the medical personnel of our nation have been moving steadily forward and have reached a peak in medical care that towers above what is available anywhere else in the world."

"No one doubts the ability of the national government to aid medical progress. The costs of medical education have increased so greatly that additional funds are necessary to maintain the high standard that has been reached. If such funds are forthcoming from the federal government, they must be granted without the control that government usually demands when it supplies financial aid. The hospital too must have the freedom that is asked for the medical schools," he emphasized.

Dr. Fishbein said that Mr. Ewing's report to the President contains "misrepresentations" and "follies so numerous that it would be impossible to correct all of them."

"One searches in vain for any suggestion as to how medical facilities and the medical personnel of the United States could be made more effective. Mr. Ewing's statement on the nation's health suggests that every state should have a medical school and a medical center around the school.

"This is a broad generalization that could be made only by someone without knowledge of medical education or its problems. A medical school is not just four walls and a lot of equipment. The fundamental factor in a medical school, as in a hospital or any other medical institution, is its medical personnel.

"Mr. Ewing's report says that a scant 20 per cent of our people are able to afford all the medical care they need. This, mind you, in a nation with the highest standard of living of any nation in the world. How pitiful then must be the situation elsewhere! The report urges that 30 per cent of American families, with incomes between $3,000 and $5,000, would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness. How many of these families make great sacrifices or go into debt to purchase a motor car or to find a place in which to live or to get something resembling an adequate diet or to purchase mink made out of dyed rabbit? Many an American family spends over $180 a year on tobacco.

"Is the answer the depreciation of medical care to a ridiculous price or education of the public to a recognition of the value of high quality medical care for human happiness?"

Ewing Picks Himself to Head Bureau

Oscar R. Ewing, according to *Washington Report on the Medical Sciences*, will be the new head of the new Federal Department which he has named Department of Human Resources. The creation of this department will probably be one of the recommendations of the commission created to study the reorganization of the government's executive branch. Herbert Hoover is chairman of this commission.

All seven physician members of the House of Representatives were re-elected and all are opposed to compulsory health insurance. Three of them are Democrats and may be bound by party obligations.

With Senator James E. Murray of Montana almost certain to be the chairman of the health subcommittee of the Senate Committee on Labor and Public Welfare, it is quite reasonable to expect that a compulsory health insurance bill will be favorably reported before the first session of the 81st Congress.

Public Health Progress in Ireland

M. L. Riccitelli, M.D., *New Haven*

Much progress in the field of public health has been made in Ireland since my first visit in 1937. I have observed that more and more attention to food cleanliness is being given in the homes, shops, and eating places. Already a number of the larger dairies are producing pasteurized milk.

The daily press, radio, and films are playing a big role. The public health minister has even now introduced a comprehensive program designed to safeguard and protect the health of the people, especially the children, and has appealed to the Irish people for cooperation in his public health program. The school teachers have been assigned the task of educating the youngsters in public health problems and matters of hygiene. The use of the 16 mm. film has already been proposed to assist in the program to create health consciousness in children. The problem of tuberculosis has been attacked with renewed vigor, with the idea of prevention occupying first place. Improved hospital facilities and establishment of new hospitals in strategic areas for the surgical treatment of tuberculosis is now under way. Mobile x-ray units will shortly be in service. Adequate housing for people who are living in condemned buildings is contemplated in a number of places and in Limerick 1,000 houses will be erected starting early next spring. The problem of reducing maternal and infant mortality rates is being set upon by the health authorities, through the introduction of more adequate hospital facilities for the care of the mother and child.

Under the sponsorship of the Irish Red Cross, courses in water safety, swimming, life saving and rescue work have been introduced this summer with the awarding of a number of certificates. Swimming and life saving are being urged on every school curriculum, through which a number of drowning fatalities will be avoided. Artificial respiration and water safety courses will also be urged for schools.

The social welfare bill, just passed, provides for increased social welfare amounting to 2,500,000 pounds a year, of which 1,500,000 pounds will go to old age pensioners and 1,000,000 pounds to the widows and orphans. Under this new bill, the blind pensioners will receive 1,500,000 pounds over what they are now getting. In addition it would enable blind persons, at present excluded, to claim pensions and would also reduce the qualifying age from 30 to 21 years. Following the passage of the bill, these changes in the health insurance act will increase its benefits to the pensioners. Next on the agenda will be a comprehensive scheme for the social services.

Another great problem is that of dental caries, which is quite prevalent among the people, and which has increased since the pre-war period. The incidence of rickets has more than doubled during this same period. A large part is, no doubt, due to a calcium deficient diet. School surveys of children with rickets, dental caries, and malformations are being contemplated under the direction of the Irish dental association. The introduction of tea into Ireland synchronized with the increase in dental caries. Whether or not there is any causal connection remains a problem for further investigation. The International Dental Federation which met in Dublin during my stay there, has gone into the problem of dental care at its scientific meetings which were held at St. Stephen's Green. This is the first to be held in Dublin, and the first was in Paris about 48 years ago. The relationship between sweets and caries, tea and caries, repair of dental tissues, dentistry for the masses and compulsory dental examination, were discussed by the various delegates. The meeting was considered highly successful.

Dr. Riccitelli visited Ireland from June 30 to September 1, 1948

NEWS FROM WASHINGTON

THE 81st CONGRESS

JOSEPH S. LAWRENCE, M.D., *Washington*

The Author. *Council on Medical Service, American Medical Association*

THE 81st Congress, which will convene on January 3, will have approximately twenty per cent new members in each House. Organization of the Houses is likely to be a troublesome problem; especially is this apt to be true in the Senate. The committee personnel will not be announced until organization is complete. The committees in which we have the most interest are likely to be manned by the people who directed them in the 79th Congress. However, there will be some changes.

In our opinion, it would be neither wise nor safe to attempt to forecast what this Congress will do in the health field before we read what the President will recommend in his message to Congress. Both political platforms recommended liberal changes in the present methods of providing medical care and a governmental responsibility for making adequate medical care more available to the public. We must wait and see how Congress will undertake to implement the platform plank. In the meantime the medical profession should recognize its opportunity and responsibility to inform the members of Congress, and especially the new members, on the problems involved in changing our medical care program. It must be recognized that we are actively changing the system ourselves through our development of prepayment plans and group practice. Our Congressmen should be familiar with the progress we are making and the plans we have for the future in this direction. They should also know of the hospital construction plans in their communities, and it is exceedingly important that they should be thoroughly familiar with the local methods of providing medical care for veterans.

In thus providing our Congressmen with information, it would be well to enlist the assistance of public leaders. If a Congressman recognizes that the profession has the good will and support of other influential segments of his constituency, it can expect his assistance in promoting legislation favorable to public welfare. It is essential, therefore, that the public be so fully convinced that our program is for the improvement of the general welfare, rather than the advancement of our private interests, that it will heartily give its open approval and join with us in accomplishing its realization. When physicians are invited to Washington to testify before Congressional committees, they are given the same consideration as any other witnesses, but the value of their testimony is multiplied many times over when the members of the committees receive from prominent individuals and organizations of their districts endorsements of the sentiment expressed by the physicians in the testimony. Naturally a man relying upon public confidence for his election to office will be loath to ignore the wishes of those people who elected him. Obviously, the advocates of federal health insurance programs will interpret the results of the present election as favorable to their programs, but they may be mistaken. We owe it to our patients to aid in organizing public sentiment for what we know to be to their best interests.

Unfinished Business

THE HOOVER COMMISSION

A Commission on Organization of the Executive Branch of the Government was established by Public Law #162, 80th Congress, to promote economy, efficiency, and improved service in the transaction of the public business in the various agencies and bureaus of the executive branch. The report of this Commission, to be submitted to the 81st Congress by January 13, 1949, will undoubtedly recommend the elimination of some government health activities and the consolidation of others. It will also comment on the creation of a department or secretariat of health.

ADVISORY COUNCIL ON SOCIAL SECURITY TO THE SENATE COMMITTEE ON FINANCE

This Council, created by S.Res. 141, was directed to make a full and complete investigation of Social Security with special reference to coverage, benefits,

and taxes. Report is being submitted in sections. Three sections have been published thus far. It recommends that the government increase its interest in extending social security coverage, financial aid to those suffering total disability, and aid to dependent children.

THE SMITH COMMITTEE

S.Res. 249 authorized the Subcommittee on Health of the Committee on Labor and Public Welfare of the Senate to continue its study of national health problems and of the relevant legislative proposals. It is to report to the full Committee on Labor and Public Welfare by March 15, 1949. The results achieved through grants-in-aid and other forms of subsidy are receiving special attention.

NATIONAL HEALTH BILL

A new health insurance bill is certain to be drafted along the lines adopted by the Federal Security Administrator in his report to the President on the National Health Assembly. His report, the Administrator admits, will not necessarily accord with the report to be submitted by the Executive Committee of the Assembly. An interested visitor to all sections of the Assembly while they were in action found a majority supporting the proposition that a health program to be most efficient must function on a community rather than on a national basis. Other bills will be introduced as suggested by the recommendations that the President may make in his message to the Congress.

DRAFT

The Department of Defense is confronted with a very acute problem in providing adequate care for the draftees whom it will collect during the next year. It was hoped that a sufficient number of physicians would volunteer for this service. If an adequate number cannot be secured in any other way, the Department of Defense may be obliged to propose a draft bill.

Various plans for deferring medical students from the draft are being considered. The wisdom of permitting students who are pursuing a medical education to continue without interruption is obvious, but there are also students engaged in other scientific fields whose importance cannot be overlooked. Where to draw the line between the essential and nonessential is a problem.

MEDICAL EXAMINATION OF CHILDREN OF SCHOOL AGE

When the 80th Congress adjourned it was considering bills (S1290 and HR1980—School Health Act) authorizing the states to set up programs for the medical examination of school children, or children of school age. Hearings were held on the bills, but the committees did not take action. It can be expected that the subject will be continued by the next Congress. The American Parent Committee, promoter of one of the bills, will hold two one-day conferences this month, one in Washington and the other in New York City, to preview legislation for children in the 81st Congress.

DISABILITY

Temporary or partial disability: One section of the National Health Program (S1734 and HR4390) before the 80th Congress provided for the payment of cash benefits to workers for the time that they might be unemployed because of illness. Three states (Rhode Island, California, and New Jersey) now have insurance laws of this character.

Permanent and total disability: Two bills (S1679 and HR4303) outlined a program of benefits for person totally disabled. The Senate Advisory Council (see above) recommends that legislation be considered in this field.

VETERANS

Two outstanding problems present themselves for solution in providing medical care for veterans.

(1) Hospitalization. The Veterans Administration has authority under Public Law #346, 78th Congress, to build an adequate number of hospitals. As presently visualized, there will ultimately be approximately 300,000 beds at a cost of upwards of one billion dollars. This building program is being developed as rapidly as possible although the Veterans Administration reports that it now has more beds available than it can staff with doctors and nurses, and there are also reports to the effect that many operating hospitals have proportionately few service connected patients. An unexpected and undesirable competition arises between the Administration's hospital building program and the development of the Hill-Burton Act. In some instances the two construction plans are operating in the same community.

(2) The other problem that is likely to engage the attention of the Congressmen is that of providing veterans with medical care for nonservice connected conditions. At present the unoccupied beds in veterans' hospitals can be made available to veterans suffering with nonservice connected conditions, if they declare themselves financially unable to

procure adequate care. Reports from the Veterans Administration show that more than three-fourths of the veterans cared for in veterans general medical and surgical facilities are hospitalized for nonservice connected ailments. The government's decision as to whether it will provide all manner of medical care for the veterans or enforce the law with regard to indigency will very definitely influence the administration of the Hill-Burton Act.

MEDICAL INDIGENT

The National Health Insurance Bill (S1520) proposed that the Federal Government assist the states in providing medical care for all those declared to be medical indigents. No satisfactorily comprehensive definition of "medical indigent" has been developed. In the meantime the Senate Advisory Council on Social Security, mentioned above, is recommending increases in the amount to be allowed for medical care to certain categories of indigents, namely the recipients of old age assistance, the blind, and dependent children.

MEDICAL EDUCATION

Proposals have frequently been made to Congress that the number of medical schools should be increased, and the National Health Bill of last year carried a provision for this purpose. Senator Thomas (Utah), who may be the new chairman of the Committee on Labor and Public Welfare, introduced a bill at the close of the last Congress providing grants and scholarships for medical education. The Senator will very likely reintroduce his bill.

PUBLIC HEALTH UNITS

Three bills authorizing the creation of a program of health units (S2189, HR5644 and HR5678) did not get beyond the hearing stage, and it can be expected that similar bills will be introduced early in the session.

APPROPRIATIONS

The Bureau of the Budget has been holding hearings on the annual requests for funds made by the various agencies of the government. Their recommendations will be submitted by the President to the Congress early in January. Sizeable requests are being made by the following agencies engaged in health activities:

The Federal Security Agency
The Public Health Service
The National Institutes of Health
Bureau of Indian Affairs
Atomic Energy Commission
National Security Resources Board
Office of Civilian Defense Planning
Research and Development Board
Children's Bureau

The Facts Are On Our Side

In a recent editorial appearing in the *Annals of the Medical Society of the District of Columbia* Dr. Maurice H. Friedman states that the Brookings report and the Senate Resolution 279 comprising the final report of the Senate Sub-Committee on Health, "signal a dramatic change in the troubled period confronting the American Physician." In the latter report the Committee stated that the existence of a serious national health problem is debatable and the present evidence does not warrant the framing of legislation at this time. "Yet," says Dr. Friedman, "we cannot afford to congratulate ourselves on the present respite. We cannot assume that the future is safe. It most definitely is not. The general public has not read the Brookings report and is completely oblivious to what has happened in the Committee hearings during the past year. The average lay person is still under the impression that our health services are woefully inadequate and that the cost of medical care could be significantly reduced by nationwide health insurance.

"The immediate future, therefore, presents the medical profession with a great opportunity and a heavy responsibility. We must teach the public how to measure the health of the community and how to assess the relative importance of physicians' services in community health. The average man and woman must be made to realize that the attainment and preservation of good health is not merely a matter of doctors, medicines, and hospitals. Each county medical society must assume the responsibility for the educational campaign in its own community. For the success of such a campaign it would be well to enlist the cooperation of the churches, the labor organizations, and other public spirited civic groups.

"There is no need for special pleading with the laity. We have nothing to conceal. Our only interest should be the presentation of the plain, unvarnished facts to the general public as fairly as we can. The facts are on our side. The medical profession has nothing to fear from the truth."

CORRESPONDENCE

Council on Pharmacy and Chemistry of the American Medical Association

Office of the Secretary
535 N. Dearborn Street
Chicago 10, Illinois

October 9, 1948

Our attention has been called to a press release just issued by the Food and Drug Administration with regard to preparations of the C. B. Kendall Company, Indianapolis, Indiana.

The office of the Council on Pharmacy and Chemistry urges you to bring this matter to the attention of the members of your society, association, or staff.

Austin Smith, M.D., Secretary

Federal Security Agency
Food and Drug Administration
Washington, D. C.

October 8, 1948

The Federal Security Agency's Food and Drug Administration warn physicians and dentists that certain codes of procaine hydrochloride solution manufactured by C. B. Kendall Company, Indianapolis, Indiana, caused severe necrotic damage upon injection. The facts came to light only recently when the American Medical Association informed the Food and Drug Administration that a physician reported injuries from a batch of the solution coded 24830.

This code was placed in distribution in February 1948. C. B. Kendall Company determined, following reports of untoward reactions, that the solution is highly acid, possessing a pH of about 1. The company attempted to recall the lot by a letter dated June 3, addressed to each purchaser of the vials, which directed their return, and by recall efforts of its own salesmen. This recall program has not been completely effective.

The Food and Drug Administration has just learned that another batch of the firm's procaine hydrochloride solution, coded 64712, has caused several alleged necrotic reactions. The pH of a vial of this lot was found to be 2.9.

Pharmacological work being performed by the Administration indicates that these two products are dangerous and should not be used. They have been distributed in the area from Florida to Wisconsin and from West Virginia to Texas.

The C. B. Kendall Company has distributed several other lots of injection drugs which possess a pH of 3.0 or less. Of these the firm has voluntarily recalled the following products on which complaints have been received:

Vitamin B Complex Stronger—Lot No. 54843
Vitamin B Complex—Lot No. 44832
Pentaboxin—Lot Nos. 44823 and 54837
Thiadoxin—Lot Nos. 34808, 44817, and 64842

Also, the following injection products of C. B. Kendall Company have shown low pH values as indicated:

Product	Lot No.	pH
Vitamin B Complex Stronger	64844	2.9
Vitamin B Complex	54811	2.8
Thiamine Hydrochloride	34817	2.6
Thiamine Hydrochloride	74806	2.9
Pyridoxine Hydrochloride	74725	2.7
Pentabexin	64812	3.0
Procaine Hydrochloride	74871	3.0

The above facts which have been obtained to date require the issuance of this notice to physicians even though the investigation has not been completed.

The Council on Pharmacy and Chemistry of the American Medical Association is assisting in the distribution of this notice through its facilities for communicating to hospitals and physicians.

Veterans Administration

Branch Office No. 1
55 Tremont Street, Boston 8, Mass.

October 22, 1948

To the Editor:

Under date of April 27, 1948 Dr. Paul B. Magnuson, chief medical director of the Veterans Administration, Washington, D. C., addressed a letter to Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* explaining the reason for establishing a fee guide schedule, outlining the procedure by which fees were determined, and requesting that if possible it be published as an open letter in the *Journal of the American Medical Association.*

Dr. Fishbein replied to this communication stating that they would be glad to publish the communication in a subsequent issue of the *Journal*, and it was so published in the May 22, 1948 issue.

In order to give this subject widespread publicity, it is the desire of the chief medical director that this letter be published in all State Medical Journals. Accordingly, I am enclosing a copy of the chief medical director's communication to the American Medical Association with the request that it be published in your State Medical Journal.

Francis B. Carroll, M.D.,
Branch Medical Director

Washington 25, D. C.
April 27, 1948

Dr. Morris Fishbein
Editor, The Journal of the
American Medical Association
535 North Dearborn Street
Chicago, Illinois

Dear Dr. Fishbein:

It has come to my attention that considerable misunderstanding has developed throughout the medical profession concerning the establishment of fees for medical services to be paid private physicians participating in the so-called "Home Town Medical Care Program for Veterans." It has been contended that the Veterans Administration has arbitrarily established a Fee Schedule which represents the maximum amount which may be paid for any given service and which is, in effect, a National Fee Schedule. It has also been contended that the various State Medical Societies and other interested groups were not consulted when this Fee Schedule was adopted.

In order to clear up any misunderstanding regarding this matter, it is desired to emphasize that my predecessor, Dr. Paul R. Hawley, had no intention at any time of establishing a National Schedule of Fees, nor do I contemplate doing so. However, the Fee Schedules originally submitted by the various State Medical Societies, when the "Home Town Medical Care Program" was inaugurated, varied so widely in format, terminology, and fees for similar or identical services, that it was deemed advisable to establish a uniform Fee Schedule Format and to set up tentative fees which could be used as a guide by the various State Medical Societies when submitting their proposals for the furnishing of medical care to veterans.

This uniform Fee Schedule Format was formulated by the Professional Group of National Consultants to the chief medical director. This group, representing the various specialties in medicine and surgery, is composed of eminent physicians from all parts of the country. Tentative fees were set up in the format after a careful analysis of Prepaid Medical Care Plan, Workmen's Compensation and Insurance Fee Schedules, and also the Fee Schedules in effect in the various States having agreements with the Veterans Administration. As was to be expected, considerable variation occurred in the Fee Schedules reviewed.

The Professional Group of National Consultants made every effort to arrive at fees that were considered to be within reasonable limits and which would, as nearly as possible, allow a uniform provisional fee schedule for use as a guide in facilitating and expediting the preparation of agreements between State Medical Societies and the Veterans Administration.

Further attempt was made to provide for elasticity in the charges for certain operations or other services which seemed to evoke more than average contention by listing the minimum and maximum amounts considered equitable. These items bear the notation "AA", which indicates that the fee for the given service is to be determined by arbitration and agreement between the Veterans Administration and the Medical Society concerned.

May I reiterate that the Veterans Administration Fee Schedule Format is in no sense to be construed as an arbitrary or National Fee Schedule. Furthermore, it is subject to periodic review and such modification as conditions may indicate.

If it meets with your approval, I would appreciate it very much if you could possibly arrange to publish this as an open letter in the *Journal of the American Medical Association*. I should like this to reach all of the physicians throughout the country, and I know of no better way to do it than through the *Journal*.

Paul B. Magnuson,
Chief Medical Director

OBITUARY

Elias Pratt, M.D.

1859 - 1948



Elias Pratt was born in Essex in 1859, a direct descendant of Lieut. William Pratt, a settler of the Hartford colony who established in Essex in 1678 an iron-making business which for eight generations was continued in direct succession from father to son. With the death about nine years ago of Dr. Pratt's brother, James, known and loved far and wide as "Uncle Jim," kindly sage and philosopher, the business passed into other hands.

Elias Pratt was graduated from the College of Physicians and Surgeons of Columbia University in 1887 and, after a period of internship at Blackwell's Island hospital, began the practice of medicine in Torrington which he continued until 1946. At the time of his retirement he was the dean of Litchfield County physicians and had held every office within the power of his associates to give him. He was in turn president of the Litchfield County Medical Association, president of the State Medical Society, president of the Connecticut Public Health Association, a trustee of the Institute of Living, Hartford, chief of the medical service of the Charlotte Hungerford Hospital, and affiliated with many other activities in the field of medicine.

Dr. Pratt was best known for his accomplishments in the field of public health. For almost 50 years he was town, borough and city health officer of Torrington and school physician. Twice he was elected to the state legislature and as a member of the public welfare committee he was instrumental in securing the passage of several health protective measures, which at the time were considered almost revolutionary, but which are now accepted as necessary and commonplace.

Dr. Pratt will long be remembered by those who had the good fortune to know him as a modest, kindly, erudite, Christian gentleman, a man of broad interests whose principle in life was to be of service to his fellowman.

Samuel A. Wadhams, M.D.

Tennessee Adopts Prepayment Plan

A voluntary program of medical care insurance has been adopted unanimously by the House of Delegates of the Tennessee State Medical Association. The plan will cover major and minor surgery, obstetrics, disclocations, and fractures, and benefits will be payable whether the service is rendered in the home, office, or hospital.

The plan will combine both the cash indemnity and service features. The schedule of benefits are to be accepted as full payment by participating physicians for services rendered to individuals earning less than $2,400 and to families whose incomes do not exceed $3,600. For persons in higher income brackets the schedule of benefits would become cash indemnity, thus allowing the doctor to charge more if he wishes.

All licensed insurance companies in Tennessee will be encouraged to participate in the program. The premiums charged will be set by the underwriting companies because "it is the desire of the Association to permit such rates to seek their natural levels through competition."

This culminates several years of planning and study on the part of the prepayment committee under the chairmanship of Robert Woods, M.D., of Knoxville. During this period the committee heard the viewpoints of practically everyone of importance in the prepayment field.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. Charles W. Goff, West Hartford
President-elect, Mrs. Ralph L. Gilman, Storrs
First Vice-President, Mrs. F. Erwin Tracy, Middletown
Second Vice-President, Mrs. Charles H. Sprague, Bridgeport
Recording Secretary, Mrs. Paul Vestal, Woodbridge
Treasurer, Mrs. Frank DiStasio, New Haven
Corresponding Secretary, Mrs. J. Whitfield Larrabee, West Hartford

DATE TO REMEMBER

On December 8 the Hartford County Auxiliary are having a Bazaar, Hobby Exhibit and Auction at the Foot Guard Hall, Hartford, to raise money for their Scholarship Fund. There will be many interesting displays and a variety of booths with articles for sale. The Auction in the evening will climax the day's activities. It is hoped that members of all the Auxiliaries will be able to come and help make this a financial success.

State Meeting

The semi-annual meeting of the State Auxiliary was held at the New Haven Country Club and proved to be very interesting. We were fortunate in having Dr. Helen Gilmore as the guest speaker at the luncheon. Dr. Gilmore is the physician-in-charge of the Psychiatric Inpatient Clniic, Grace-New Haven Community Hospital University service. Her subject was "Psychiatry Has a New Look." She spoke of the changed attitude toward mental illness and the part that doctors' wives could play in making this more hopeful attitude clearer to the public. The body and mind are no longer considered separate entities and the psychiatrists, medical men, surgeons, obstetricians and pediatricians are now united as a team. She stressed the preventive aspects and pointed out that as the emotional difficulties of children are more clearly realized they have a better opportunity of growing into more stable individuals. The question and answer period which followed showed how interested the members are in this subject.

At the business meeting following, Mrs. Charles Goff, president, gave a short resume of the activities of the counties. She stated her pleasure at the interest and enthusiasm being shown by the Auxiliary as a whole and urged all members to help make the new *Bulletin* a success. Three of the delegates at the National convention last June gave the highlights of the convention and the chairmen of the various committees gave short reports of their activities. A condensed report of these follows:

Legislature—A digest of impending legislature is being prepared for the members and they are urged to study this so they will be intelligently prepared to inform others.

Hygeia—The price of *Hygeia* has been raised but it is well worth the additional price and members were urged to see that it reaches an ever increasing public.

Nurse Recruitment—In working for this project it was suggested that the counties form committees in each of the towns so that more personal and efficient contacts may be made.

Public Relations—A survey is being made of the health services in the State so we shall have this information for the use of the public.

Membership—There are now 768 members in the Auxiliary.

Mrs. Ralph L. Gilman, president-elect, has just returned from a National Auxiliary Conference in Chicago of presidents, presidents-elect, officers and committee chairmen. She was our delegate to this conference and gave a full report of it. The need of the auxiliaries to support the medical profession in its efforts to keep its freedom was stressed. A fuller report of this conference will be given by Mrs. Gilman in the next issue of the Journal.

Fairfield County

The semi-annual meeting of the Woman's Auxiliary to the Fairfield County Medical Association was held at the Ridgewood Country Club, Danbury. A delightful buffet luncheon was served preceding

the guest speakers and business meeting.

Mr. Douglas Stewart of the D. M. Read Co. discussed "Gifts for Men" and displayed many interesting and useful items. Miss Agnes Ohlson, R.N., director and secretary of the State Board of Examiners for Nursing, spoke on "Nurse Recruitment." Mrs. Ruth Kenzie, rehabilitation director at Laurel Heights Sanitarium, thanked the Auxiliary for gifts made possible by our project fund.

Reports of various committees were given. Mrs. W. A. Geer reported the dinner dance held at Cobb's Mill, Westport, as being socially and financially successful, $564 being realized.

Mrs. J. Grady Booe, president, welcomed the members. She introduced Mrs. Charles H. Sprague who brought a message from Mrs. Charles W. Goff, State Auxiliary president.

Hartford County

The semi-annual meeting of the Hartford County Auxiliary was held at the Hartford Golf Club and was very well attended. Reports of the committee chairmen were given and Mrs. George Wulp, public relations chairman, and Mrs. John Larkin, legislative chairman, both announced meetings to be held in November. Mrs. Louis Gold presented plans for the bazaar to be held on December 8 and urged all members to make this a big success. Plans for a rummage sale in the winter and a concert in March are also underway. Dinner was served after the meeting and the president, Mrs. Ralph Ogden, welcomed the members and told of the work being done and planned. Mrs. Louis Gold introduced the speaker, Mr. Roy L. McLaughlin, director of the State School for Boys at Meriden, who gave an interesting address on "Child Welfare Versus Youth Authority."

Hartford County now has 279 members and is justly proud of that figure.

Middlesex County

The fall meeting of the Middlesex County Auxiliary was held at Bengston-Wood Hall, Middlesex Hospital. A letter was read from Mr. Russell, executive secretary of the Joint Committee of the State Mental Hospitals, to Mrs. Walter Nelson, who last year took charge of the Christmas Gift project for Middlesex County. Mrs. Nelson agreed to act as chairman again this year. The president, Mrs. Edgar Yerbury, introduced Mrs. C. W. Goff, State Auxiliary president who spoke briefly on the fundamental purposes of the Auxiliary and its task in serving as an intermediary between the medical profession and the public.

The speaker for the afternoon was Mr. Julie Holzberg, an authority in the field of remedial reading, whose subject was "Psychological Implications of Reading Difficulties in Children."

At an executive meeting it was decided to continue the work on gauze and sewing for the Middlesex Hospital which had been started last year and the fourth Monday afternoon of the month was chosen for this work. The Auxiliary have also collected old hats for distribution to the women patients at the Connecticut State Hospital.

New Haven County

The fall meeting of the New Haven County Auxiliary was held in New Haven. Dr. Fredrick Redlich, professor of psychiatry at Yale Medical School was the guest speaker. A tea followed the meeting.

The Auxiliary voted to contribute $25 to the Social Workers' Fund at Undercliff and to assist in the collection of Christmas gifts for the patients in the mental hospitals. The Auxiliary has also adopted the Rheumatic Fever and Cardiac Clinic at New Haven as one of its projects and expects to assist in whatever capacity needed. Mrs. Barnett Freedman asked for volunteers to help with the work.

Mrs. Robert Cook, vice-president of the Auxiliary, entertained the members of the Board at a luncheon at her home in New Haven preceding the meeting.

New London County

Mrs. Mildred Carney, public health nurse of New Haven, was guest speaker at the semi-annual meeting of the New London Auxiliary held at the Mohican Hotel. Mrs. Carney used as her subject "Heart and Rheumatic Fever." She told of the heart clinic for children that has been established in New Haven, and expressed the hope that the doctors' wives would assist with the work.

A business meeting followed with Mrs. Julian G. Ely presiding. She introduced Mrs. Ralph Gilman of Storrs, president-elect of the State Auxiliary, who gave a brief resume of the National Convention in Chicago last June. Mrs. Gilman also gave a few suggestions for work to be done by the Auxiliary.

Mrs. Ely thanked the members for the number of books donated to the nurses' library at Uncas-on-Thames in answer to an appeal from Dr. Michael Ferrara, assistant superintendent. A committee was appointed to solicit books from month to month. The Auxiliary will help with the sale of tuberculosis seals in answer to an appeal from the New London Visiting Nurse Association.

The Auxiliary has eleven new members.

National Institute of Dental Research

The National Institute of Dental Research, established under authority of an Act of Congress approved by President Truman on June 24, will conduct a broad attack on dental diseases, and related diseases of the mouth, which are the most common ailments of mankind. The program, for which Congress authorized appropriations of $750,000 a year, will include research in the Institute's own laboratories at Bethesda; financial grants to outside institutions for research and training of professional personnel; and fellowships and traineeships in the Institute to promote training and research in dental diseases, their diagnosis, prevention, and treatment.

The law creating the National Institute of Dental Research authorized an appropriation of $2,000,000 for erection of a special research building to house the new Institute, but the money has not yet been appropriated. Pending construction of this building, the Institute will be housed in present structures of the National Institutes of Health.

The new Institute will take over the work now being done in the Dental Research Section headed by Dr. H. Trendley Dean in the National Institute of Experimental Biology and Medicine. The section has been responsible for most of the basic research on the effect of fluoride in water on dental caries, and is now experimenting, in cooperation with the Michigan State Health Department and the University of Michigan, on the mass prevention of dental caries through the fluorination of public water supplies. The development of the technique for individual application of fluorine by dentists is being carried on in the Dental Health Section of the Public Health Service under Dr. John W. Knutson, direction of the Section.

Much research remains to be done on the prevention of dental cavities by the use of fluorine. But an even more productive field of research for the new Institute may be in the field of periodontal diseases—the diseases which attack the gums and tissues surrounding the teeth, and which account for most loss of teeth in people beyond 35 years of age.

Young Physicians Urged to Enter Service

The Council of the Illinois State Medical Society recently adopted a resolution urging all young physicians to volunteer immediately for military service. The resolution, introduced by Dr. Edwin S. Hamilton of Kankakee, who is also a trustee of the American Medical Association, was passed unanimously by the Council, which represents practically all the 13,000 physicians of the state.

The resolution is directed especially at those young doctors who received all or part of their medical education at the expense of the government, under the wartime A.S.T.P. and V12 programs, but who did not serve in the armed forces because the war ended before they had completed their courses.

Such students were obligated, by the terms of their contracts with the government, to enter the service when called on at any time up to three years after their training was ended. Since the programs were cancelled in 1945, the three-year period has run out on most of these men, and they are not legally liable to be called.

However, the resolution stated that they are still under a moral obligation to repay the nation for their expensive education, aside from their duty as citizens.

A number of such students are now completing residencies or other services in preparation for specialization in some branch of medicine. Dr. Hamilton, in presenting the resolution to the Council, pointed out that plans are being made for such men to complete their specialized training in armed forces hospitals or to credit time spent in service to their specialty training.

In addition, said Dr. Hamilton, many medical schools, laboratories, clinics and hospitals have substantial numbers of such men on their staffs, many of them under some deferred classification. The medical profession must bring all possible pressure to bear on such institutions to release eligible men for military service, he said.

SPECIAL NOTICES

LECTURE ON GLAUCOMA PROBLEM

The Mark J. Schoenberg Memorial Lecture will be held at the New York Academy of Medicine at 8:00 P. M., Monday, December 6, under the joint sponsorship of the New York Society for Clinical Ophthalmology and the National Society for the Prevention of Blindness. John N. Evans, M.D., of Brooklyn, will discuss "Circulatory Aspects of the Glaucoma Problem."

This lectureship was established as a memorial to Dr. Schoenberg's interest and original work in the control of glaucoma.

The committee in charge of arrangements for the meeting is composed of James W. Smith, M.D., Chairman; Isadore Givner, M.D.; Willis S. Knighton, M.D.; Franklin M. Foote, M.D.

The lecture will be preceded by an illustrated talk on "Observations on the Anterior Chamber Angle with the Gonioprism" by Harvey E. Thorpe, M.D., of Pittsburgh.

CONNECTICUT VA MEDICAL SOCIETY

The following clinical conferences will be held during December at the Veterans Administration Office, 355 Fairfield Avenue, Bridgeport, from 8:30 A. M. to 9:30 A. M. on the dates indicated:

December 1

Roentgenologic Aspect of Gallbladder Diseases
Robert D. Russo, M.D., radiologist, Bridgeport

December 8

Interesting Urological Problems
Sidney H. Beck, M.D., urologist, St. Vincent's Hospital, Bridgeport

December 15

Brachialgia
Anthony L. Camarda, M.D., orthopedist, Hospital of Special Surgery, New York

December 22

Some Etiologic Factors in the Psychoneuroses
Mildred Pellens, M.D., neuropsychiatrist, Bridgeport

December 29

Malaria
John LoCricchio, M.D., pathologist, St. Vincent's Hospital, Bridgeport

The weekly medical conferences of the Connecticut Veterans Administration Medical Society are held every Thursday at 8:30 A. M. at the Veterans Administration Building, 95 Pearl Street, Hartford. The medical profession is invited to attend these meetings.

The December program follows:

December 2

Speaker: Paul Kunkel, chief of medical services
Subject: Problems in Diagnosis and Treatment of Diseases of the Chest.

December 9

Speaker: Alfred Hurwitz, chief of surgical services
Subject: Problems in Diagnosis and Treatment of Surgical Lesions of the Colon

December 16

Speaker: Louis P. Hastings, pathologist, St. Francis Hospital
Subject: Differential Diagnosis of Jaundice

December 23

Speaker: Philip Morse, psychologist, Mental Hygiene Clinic, Hartford Regional Office
Subject: Rorschach and Thematic Apperception Test

December 30

Motion picture on Secondary Anemias

ANNUAL ASSEMBLY — ACADEMY OF GENERAL PRACTICE

Eighteen outstanding medical teachers have been selected by the Program Committee for the first Annual Scientific Assembly of the American Academy of General Practice to be held in Cincinnati, at the beautiful Netherlands Plaza Hotel next March 7, 8, and 9. The names of the essayists and their subjects will be announced later. Indications are that the leading pharmaceutical and equipment manufacturers of the country will be represented in the technical exhibit. A separate registration desk and a hospitality desk will be maintained for the ladies and a series of pleasant social functions are being planned for them.

The Assembly will open at 9:00 A. M. on Monday, March 7, with an invocation and greetings from representatives of the mayor of Cincinnati and the local medical society. The opening general session will be closed with the Presidential Address of Dr. Paul A. Davis. The first scientific paper will be presented at 9:30 A. M. in the spacious and comfortable Hall of Mirrors.

On Monday evening there will be a dinner for secretaries and presidents of constituent state chapters. The annual banquet for all members, their wives and friends will be held on Tuesday evening. The meeting will close at noon on Wednesday, March 9.

The Congress of Delegates will meet at 10:00 A. M. on Sunday, March 6, preceding the Assembly and again, for its second session, on Tuesday afternoon.

Arrangements have been made to accommodate more than 2,000 members and their wives. Non members of the Academy may attend the Assembly as guests on payment of a registration fee of $5. Only Doctors of Medicine may register. There will be no registration fee for members. Banquet tickets will be sold at $5 per plate.

A printed form for requesting hotel accommodations will be sent to all members later. Members wishing to make reservations now may do so by addressing the Chairman, Sub-Committee on Hotels, American Academy of General Practice, Dixie Terminal Building, Cincinnati 2, Ohio.



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RESEARCH IN THE SERVICE OF MEDICINE

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INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES

The first International Congress on Rheumatic Diseases ever held in the United States will take place at the Waldorf Astoria in New York City May 30 to June 3, 1949, inclusive. This seventh International Congress is sponsored by the International League against Rheumatism. The host is the American Rheumatism Association in cooperation with the New York Rheumatism Association.

Seven (5 morning and 2 afternoon) scientific sessions are planned. Also 5 one-hour round table conferences on various clinical topics will be held under the leadership of authorities in the respective fields. Short clinics, papers and reports will be given concurrently at 4 or 5 New York hospitals during 3 afternoons. Evening entertainment will be provided. The registration fee is $10.

Instantaneous translations of the scientific papers will be made by means of I.B.M. Wireless system similar to that used at the sessions of the United Nations. The official languages of the Congress will be English, French and Spanish.

The Congress has the official sanction of the United States Department of State which will cooperate in the issuance of official invitations. This is an open meeting. Members of the International, the European, and the Pan American Leagues against Rheumatism as well as the Canadian Rheumatism Association, British Empire Rheumatism Council, the Heberden Society of London, and the 10 state or city Rheumatism Societies affiliated with the American Rheumatism Association are especially invited.

The annual American Medical Association scientific convention will be held in Atlantic City (3-4 hours from New York) during the week following the Congress (June 6 to June 10, 1949) after which a postconvention tour has been planned.

Further information concerning the Congress will be released in the future.

NATIONAL MENTAL HEALTH FOUNDATION AWARD

The National Mental Health Foundation announces the Psychiatric Aide of the Year Award for 1948.

$500 and an appropriate citation will be presented in January 1949 to the man or woman employed as a psychiatric aide or attendant in a United States mental hospital, who is judged to be worthy of the title, "The Psychiatric Aide of the Year."

The award will be made on the basis of the following qualifications:

1. Skill, initiative and imagination in the discharge of his or her duties; kindness and devotion to the patients in his or her care.

2. Performance of the most outstanding service to his or her patients during the calendar year 1948.

3. Citizenship as demonstrated by his or her participation in the life of the community.

In addition cash awards of $50 each and appropriate citations will be made to those five nominees deemed worthy of honorable mention.

The purposes of the award are: to focus attention on the important role played by psychiatric aides and attendants in the care of the mentally ill; to help gain prestige and dignity for those engaged in the profession; and to encourage the promotion of higher standards of on-the-ward care.

The board of judges will be composed of persons prominent for their interest in the field of mental health.

Address all inquiries to National Mental Health Foundation Award, 1520 Race Street, Philadelphia 2, Pennsylvania.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1949 AWARD CONTEST

The National Gastroenterological Association again takes pleasure in announcing its Annual Cash Prize Award Contest for 1949. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in October of 1949.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving Certificates of Merit, in its official publication, *The Review of Gastroenterology*.

All entries for the 1949 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies accompanied by an entry letter, and must be received not later than April 1, 1949. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

VA NEEDS TB PHYSICIANS

One hundred full time doctors are needed by Veterans Administration for duty in its tuberculosis hospitals.

Applicants should address their inquiries to the chief medical director, Veterans Administration, Washington 25, D. C.

The openings are scattered throughout the nation among VA hospitals specializing in the treatment of tuberculous veterans and in VA general medical and surgical hospitals operating tuberculosis departments.

The salary scale for full time doctors in VA's Department of Medicine and Surgery ranges between $4,479 and $10,305 annually for jobs now open.

During the past year, 18,222 tuberculous veterans were admitted to VA hospitals for treatment. Discharges during the same period totaled 18,701.

The Connecticut State Medical Journal

Has made arrangements through its JOURNAL to secure MEDICINE OF THE YEAR for those of its members who wish to subscribe. MEDICINE OF THE YEAR is an annual review of medical progress which will appear as a supplement to the JOURNAL early in 1949. It will be a descriptive and analytical account of progress in medical science and practice during the preceding year presented in a practical, useful, and informative manner, particularly as it relates to the everyday practice of general medicine and the specialties.

The editorial management is under the direction of Dr. John B. Youmans, Dean, College of Medicine, University of Illinois. The principal contributors and their subjects are the following well-known medical educators and writers.

Internal Medicine—Dr. Hugh J. Morgan, *Professor of Medicine, Vanderbilt University, Nashville, Tennessee.*

Obstetrics—Dr. Frank Whitacre, *Professor of Obstetrics and Gynecology, Memphis, Tennessee.*

Pediatrics—Dr. Henry G. Poncher, *Professor of Pediatrics, University of Illinois, Chicago, Illinois.*

Surgery—Dr. Warren H. Cole, *Professor of Surgery, University of Illinois, Chicago, Illinois.*

ASSOCIATE CONTRIBUTORS IN MEDICAL SPECIALTIES

Allergy—Dr. Harry L. Alexander, *Washington University, St. Louis.*

Pulmonary Disease—Dr. J. Burns Amberson, *Bellevue Hospital and Columbia University, New York.*

Metabolism and Endocrinology—Dr. Kendall Emerson, Jr., *Peter Bent Brigham Hospital, Boston.*

Dermatology—Dr. Chester N. Frazier, *Harvard University and Massachusetts General Hospital, Boston.*

Cardiovascular Diseases—Dr. William J. Kerr, *University of California and University Hospital, San Francisco.*

Neurology—Dr. H. Houston Merritt, *Montefiore Hospital, New York.*

ASSOCIATE CONTRIBUTORS IN SURGICAL SPECIALTIES

Otolaryngology—Dr. A. C. Furstenberg, *University of Michigan, Ann Arbor.*

Anesthesia—Dr. Robert Dripps, *University of Pennsylvania, Philadelphia.*

Ophthalmology—Dr. Derrick Vail, *Northwestern University, Chicago, Illinois.*

Orthopedics—Dr. Allan DeForrest-Smith, *New York Orthopedic Hospital* and Dr. Harrison L. McLaughlin, *Columbia University, New York.*

Urology—Dr. Cornelius W. Vermeulen, *University of Illinois, Chicago.*

Neuro-Surgery—Dr. Howard Naffziger, and Dr. Edwin Barkley Boldrey, *University of California, San Francisco.*

General Surgery—Dr. Warren H. Cole, *University of Illinois, Chicago.*

This annual review of medical progress is being offered to members of state medical societies and subscribers to state medical journals. Of the subscription price your Association will retain a part to defray any costs associated with the announcement of this service and the handling of subscriptions. In order to secure this service, subscriptions from approximately one-third of our members and subscribers is required. Because of the short time available, subscriptions must be entered promptly. DO NOT DELAY. Send in the coupon below, or write directly, sending check or money order. If an insufficient number of subscriptions is obtained, no obligation will be incurred and your money will be refunded. ACT NOW.

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OUR NEIGHBORS

Massachusetts

Boston University School of Medicine celebrated its one hundredth anniversary in October. It began its career in November 1848 as the Boston Female Medical College.

New Hampshire

At the 1948 meeting of the House of Delegates of the New Hampshire Medical Society it was voted, strangely enough, that no official delegates be appointed to attend the meetings of the medical societies of the other New England states. Before the last war the New Hampshire Society was accustomed to send such delegates. The other New England societies have continued this custom.

New York

New York City had its first symposium on industrial health problems for New York business men on December 1. This symposium was sponsored by the Commerce and Industry Association of New York, Inc., together with the Institute of Industrial Medicine, N. Y. University-Bellevue Medical Center. It has been endorsed by the county medical society and by the AMA.

* * * *

United Medical Service (New York) recently enrolled its one millionth member. It has more than 16,000 participating physicians. This has all transpired within three years time.

* * * *

The appointment of Dr. Samuel A. Brown, formerly president of the New York Academy of Medicine, and dean emeritus of the New York University College of Medicine, as acting chairman of the Board of Trustees of the New York University-Bellevue Medical Center has been announced. Dr. Brown replaces Richard W. Lawrence, whose death occurred recently.

As chairman, Dr. Brown will head the board, which was formed in May of this year to direct the affairs of the new medical center, which includes in addition to the College of Medicine, the Institute of Rehabilitation, the Institute of Industrial Medicine and the University clinic. The Medical Center is also responsible through its teaching faculty for a major portion of the medical care given at Bellevue Hospital.

Dr. Brown is a graduate of the University Medical College (New York University), class of 1894, a Fellow of the American College of Physicians, and consulting physician on the staffs of Bellevue Hospital, New Rochelle Hospital, and Memorial Hospital. He was appointed to the University Council, April 25, 1932.

He was president of the Medical Alumni Association of the university, 1923-24, and received the university's Medallion Alumni Award in 1932.

NEWS
from County Associations

Fairfield

Stuart L. Joslin, M.D., of Fairfield has been appointed by the Board of Selectmen to fill a vacancy on the Fairfield Health Commission due to the resignation of Raymond A. Sterrett, M.D., of Southport because of illness.

Clayton B. Mather, M.D., health director of the Monroe County Health Department, Michigan, has been appointed to succeed Thomas J. Bergin, M.D., as Greenwich Health Officer. Dr. Mather began his duties November 1.

T. O. Murray of Danbury has accepted a commission in the U. S. Army and has been appointed Section Pediatric Medical Specialist. Dr. Murray has closed his office in Danbury and reported to the William Beaumont General Hospital, El Paso, Texas.

Hartford

Maurice T. Root of West Hartford was one of the guest speakers on the two day program of the American Cancer Society at its annual meeting in New York City in November.

Wilmar M. Allen, director of the Hartford Hospital, has been elected to the board of trustees of Connecticut College. Dr. Allen was president of the Connecticut Hospital Association in 1939-1940, president of the New England Hospital Assembly in 1942-1943, and regent, member of the executive committee, and chairman of the finance committee

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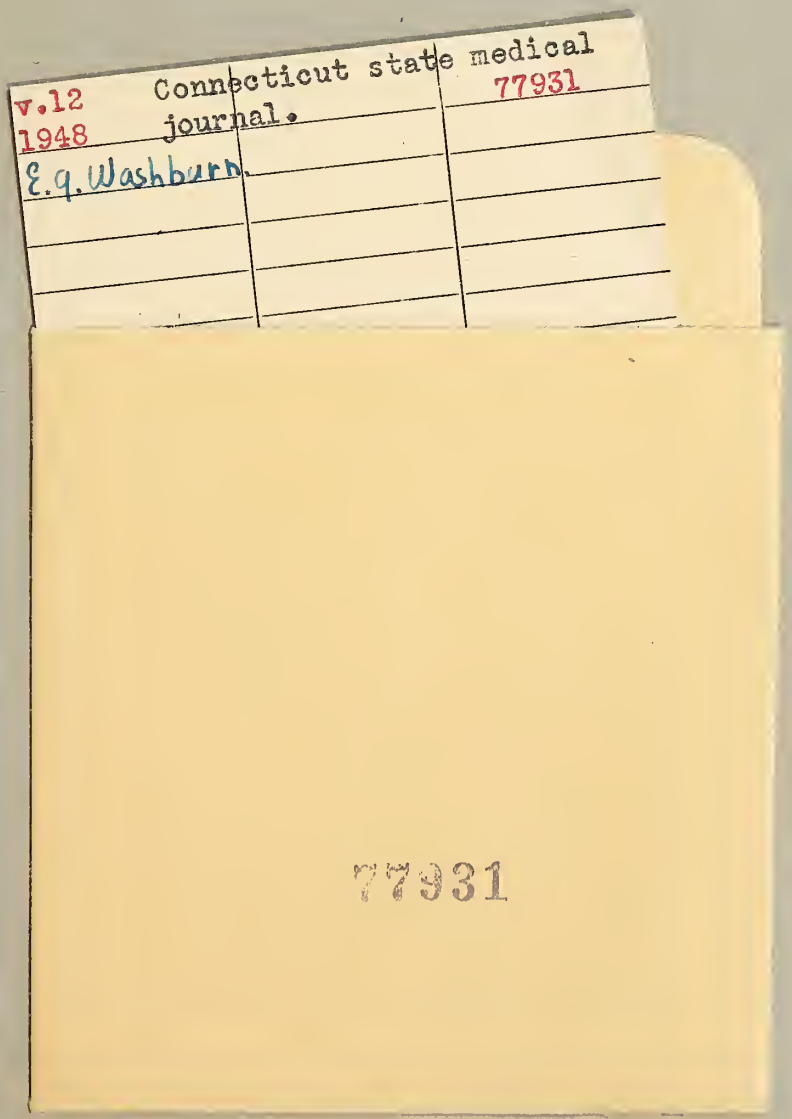
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